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Mc Inerney, Patricia Anne-Marie

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THE DEVELOPMENT OF A COMMUNITY-BASED, PROBLEM-BASED LEARNING CURRICULUM IN THE UNDERGRADUATE DEGREE IN NURSING WITH SPECIAL EMPHASIS ON THE CHILD-BEARING WOMEN IN WOMEN'S HEALTH.

Patricia Anne-Marie Mc Inerney

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of

Doctor of Philosophy

Johannesburg, 1998.

DECLARATION

I, Patricia Anne-Marie Mc Inerney, declare that this thesis is my own work. It is being submitted for the degree of Doctor of Philosophy in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

P. Mc Inerney (Signature of Candidate)

12th day of January 1999.

DEDICATION

This study is dedicated to all women -
my hope is that health services will improve and
become more sensitive to their needs.
Also to all students in the nursing profession
that your teachers will recognise you as co-learners
and the life experiences that you bring with you.

PUBLICATIONS AND PRESENTATIONS

Publication.

Mc Inerney, P.A. (1998) Recurriculating to a problem-based learning curriculum: The Wits experience. Curationis 21 (June) : 53-56. (See Annexure U)

Presentations

The Development and Structure of an Undergraduate Nursing Curriculum Utilizing Problem-based Learning. Presented at the first international nursing education conference of the nursing education research unit, Mc Master University. Create the Future, Celebrate the Past : Global Connections in Nursing Education. 17-20 June 1996.

Recurriculating to a problem-based learning curriculum : The Wits Experience. Presented at a national workshop hosted by the Department of Nursing Education, University of the Witwatersrand, August 1996.

Peer Group Evaluation of Conceptual Framework and Curriculum Models. University of the Witwatersrand, October 1998.

An abstract entitled: The Use of Focus Groups in Curriculum Evaluation and Design was accepted for a poster presentation at the 5th International Qualitative Health Research Conference to be held in April 1999 in Newcastle, Australia.

ABSTRACT

A conceptual framework was developed based on Fawcett's conceptual framework and Stufflebeam's Decision Making Model. The merging of the concepts of the framework and the model gave rise to the concepts of the research model, viz. environment, registered midwife, curriculum and outcome. These concepts were researched. Donabedian's Quality Assurance Model and Parlett and Hamilton's Illuminative Evaluation guided the research methodology. The methodology adopts a triangulated approach, making use of both quantitative and qualitative data collection procedures.

In order to study the concept "environment" 250 women were interviewed post-natally in order to determine their perceptions and expectations of care during pregnancy, labour and the puerperium. The findings show that women are not empowered in terms of their expectations of care. Caring appears to be viewed at a very low level and to be task-focused. Furthermore, caring around the birth process appears to be seen as best when it is hospital-based. Attention needs to be given to health information and health promotion. This concept was also studied through four focus groups held with women in the community. These data were analysed qualitatively. The findings revealed women's dissatisfaction with the role and function of the nurse. Women's lack of empowerment was evident in their encounters with health care professionals. Women related more negative than positive experiences of relationships with nurses. Perceptions of lack of trust and lack of concern, inter alia, in and from nurses were highlighted in the interviews.

The concept "registered midwife" was studied by requesting registered midwives in a large academic hospital's maternity unit to complete a questionnaire. The questionnaire aimed to obtain the midwives perceptions of the needs of women during pregnancy, labour and the puerperium. It also probed midwives perceptions of their roles and functions. The findings reveal that midwives recognise their teaching responsibility, but appear to have difficulty in meeting this responsibility. Her own education has prepared her for hospital-

based practice. Administration, research and policy-making are not priority roles for the majority of the respondents.

"Curriculum" was studied through two questionnaires given to students in the B.Nursing programme. The findings revealed a need to increase curriculum content which relates to primary health care and a need to restructure practical learning opportunities as students do not feel competent to practise in rural hospitals and community settings.

The concept "outcome" was studied through two sets of focus groups. One with graduands who were currently in midwifery practice and the other with supervisors of these practitioners. The findings from the graduands' groups highlighted the need for greater emphasis on culture, health information and promotion and holistic care in their learning experiences. The groups held with the nursing supervisors highlighted their perceptions of student needs and the inadequacy of the hospital as a learning environment.

The findings from the four concepts have been used to develop a curriculum for Women's Health. The curriculum model encapsulates Stufflebeam's model and the concepts of the conceptual framework. The curriculum process utilizes problem-based learning and community-based education as the means to learning.

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LIST OF ABBREVIATIONS

AIDS	auto-immune deficiency syndrome
BA(Cur)	Bachelor of Arts (Curationis)
BA(Cur)(Hons)	Bachelor of Arts (Curationis)(Honours)
BCur	Bachelor Curationis
B. Nursing	Bachelor of Nursing
BSc(Nursing)	Bachelor of Science in Nursing
CBE	Community-based education
Cert Neurmed/surg	Certificate in neuromedical/surgical nursing
CHN	Community Health Nurse
Dip Adv N Sc	Diploma in Advanced Nursing Science
DipIntN	Diploma in Intensive Care Nursing
DLitt et Phil	Doctor of Literature and Philosophy
DNEd	Diploma in Nursing Education
DOTT	Diploma in Operating Theatre Technique
ENT	ear, nose and throat
HIV	human immuno virus
MA(Cur)	Masters in Arts (Curationis)
Msc(Nursing)	Master of Science in Nursing
MOU	midwife obstetric unit
PBL	problem-based learning
PhD	Doctor of Philosophy
Pret	Pretoria
RM	Registered Midwife
RN	Registered Nurse
RNA	Registered Nurse Administrator
RPN	Registered Psychiatric Nurse
R Adv PN	Registered Advanced Psychiatric Nurse

RT	Registered Tutor
UK	United Kingdom
Unisa	University of South Africa
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Yet the timeless in you is aware of life's timelessness,
And knows that yesterday is but to-day's memory and to-morrow is to-day's dream.
(Gibran 1997:70)

Both nationally and internationally, nursing appears to be in a crisis. This crisis is apparent in nursing education as a whole and in particular in women's health. A number of factors may be identified in relation to this crisis. In teaching the knowledge of nursing, nursing education is struggling to cope with the knowledge explosion. The current curriculum and methods of teaching cannot accommodate the almost daily growth in knowledge and technology. Thus nurse educators are being obliged to seek alternative methods to preparing practitioners for nursing. Added to the knowledge explosion is the ever increasing costs of providing health care. This has resulted in changes in government policies and forced the identification of health priorities within the country. One of the health priorities which has been identified is women's health (African National Congress 1994a:57).This has highlighted the fragmentation of the teaching of women's health in the nursing curriculum. The word "midwife" means "with woman" and this should apply even more so as care extends into the primary care arena.

The result of all these factors is crisis and conflict in nursing and it is therefore necessary that change takes place in nursing education. In order to ensure that change is meaningful and appropriate, the time is right to conduct research in the area of the nursing curriculum, especially in the teaching of women's health. Internationally, community based education and problem-based learning have been considered appropriate strategies to prepare practitioners who are better able to meet the needs of health care systems that are primary health care orientated. In addition, the emphasis on self-directed learning prepares practitioners who are better prepared to cope with the knowledge explosion.

1.1 BACKGROUND TO THE STUDY

The Department of Nursing Education at the University of the Witwatersrand offers a four year undergraduate degree in nursing. The theoretical component of the midwifery curriculum is taught in what is best described as a traditional curriculum. Teaching is mainly through the lecture method, although problem-solving techniques are applied throughout the courses. The practical component is mainly obtained in a high-tech, first world provincial institution, which is also a referral centre. The learning environment prepares the student to manage the needs of the labouring women using cardiotocographs for the monitoring of labour progress and vital signs. Pain control is managed through the use of medication and epidural anaesthesia (the injection of local anaesthetic into the epidural space of the spine. It results in loss of sensation). Being a referral centre, the student is exposed to an increasing Caesarian Section rate. This means that her exposure to normal labour and midwifery care through simple intervention strategies is limited. The labour ward ambience is one of high-tech and high care and the stressful nature of the ward appears to emphasize a curative approach to care.

The patient load has demanded that postnatal care be reduced to a minimum. This has resulted in patients who have had normal vaginal deliveries being discharged six to eight hours after delivery and in some instances directly from labour ward. Thus the student obtains little or no practical experience in the art and science of promoting breastfeeding and postpartum care of the mother and child. For the woman, it means that opportunity for health promotion through education is severely curtailed. Therefore it can be argued that knowledge content and learning opportunities need to be evaluated in terms of meeting the health needs of the mother and the learning needs of the student.

1.1.1 THE NURSING CURRICULUM AND WOMEN'S HEALTH

The nursing curriculum has reinforced the fragmentation of women's health which is evident in the health care services. It has taught aspects of women's health care across the four nursing disciplines. Prior to the introduction of the four year integrated diploma and degree programmes, nursing was a three year general nursing diploma or a four year degree

programme which allowed the student to register as a general nurse and a midwife. Women's health consisted of a module in gynaecology which was taught in the general nursing curriculum. This module focussed on the pathologies, such as fistulae and carcinomas. On the "non-pathological" side, the focus of attention was disturbances in the menstrual cycle, abortion and contraception. Students who had done the three year diploma course had the option to study midwifery through a one year post-registration diploma in which the traditional components of pregnancy, labour, and the puerperium were taught. The four year degree has always included midwifery, but it was taught as a separate component and was not integrated with the general course component. The need to produce comprehensively qualified nurses capable of meeting the needs of the community, especially in the rural areas where doctors are in short supply, led to the development of the four year integrated courses which incorporate the four major nursing disciplines. Thus, unlike other countries, e.g. The Netherlands, midwifery is considered to be part of nursing and midwives have struggled to maintain their own identity. The introduction of the four year programme in 1985 did not resolve the problems associated with the teaching of women's health. General nursing has its component of women's health in the form of the pathophysiologies, community health in the form of rape and women abuse and psychiatric nursing in the form of counselling women with these problems.

1.1.1.1 MIDWIFERY AND WOMEN'S HEALTH

Midwifery, traditionally, has always only focused on childbearing and yet problems such as rape and woman abuse may well be relevant to the pregnant woman. Thus each discipline has tended to claim its share of the teaching and there has been no correlation and integration of the teaching. The legislation governing the practice of the registered midwife emphasises pregnancy, labour and the puerperium and the directives for the implementation of the four year programme do not provide guidelines for the integration of women's health. One of the intentions of the four year programme was to prevent duplication of learning material, however it retained the existing content without restructuring it. One is therefore, left to decide where the concepts relevant to women's health best fit. There can be no doubt that

communication and counselling skills, although taught in psychiatric nursing, are very necessary components of holistic care. Examples of women's health issues where such skills are essential are abortion and woman abuse.

1.1.1.2 RESEARCH RELATED TO THE FOUR YEAR COURSE

Gwele (1996a) carried out a comparative descriptive study to determine the behaviours and skills of nurse educators in implementing four basic components in the four year curriculum, viz. rendering comprehensive health care, nursing holistically, thinking critically and learning independently. Forty-seven nurse educators were purposively selected. She found that 26 nurse educators were not teaching for comprehensive health care and 22 were not teaching for critical thinking. To the researcher's knowledge no research has been done to determine the extent to which the four year programme is comprehensive and integrated.

1.2 REASONS FOR THE STUDY

1.2.1 WOMEN'S HEALTH AND HEALTH CARE

The impact of women's health on a country cannot be denied. From puberty onwards, women's health has a major impact on the country's economy, health of the nation and the type of health services needed (Doyal 1995). Conditions such as teenage pregnancy, sexually transmitted diseases, AIDS, carcinomas of the cervix and the breast and the maternal depletion syndrome all impact on the health services and the nation as a whole. The factors associated with these conditions need to be addressed at primary health care level. The current practical opportunities afforded the students do not prepare them for this approach to health care. Instead they are socialised into tertiary care. Many of the students are from a disadvantaged educational background and from areas which are in need of health care workers. The practical environment socialises them into the security of technology and prevents those who are from the rural areas from returning to practise in their communities. Thus it can be said that the current high tech and high care practical learning environments are not suitable venues for the preparation of midwives, able to function at primary health care level. Some students have stated that the high tech, high care environment does not provide them with

good role models, while experience at a primary care clinic gave others the "chance to really develop skills." One student went on to say that she had learned more in one week in a primary health care setting than she had in two years at the academic institution.

In addition, the narrow interpretation given to women's health has had its influence on the education of nurses. Nurses have been educated to understand the pathology of women's health in the general nursing curriculum and nurse-midwives have been educated to care for women during pregnancy and childbirth. In South Africa this fragmentation of health care has probably been aggravated by the shortage of doctors, particularly in the rural areas, where nurses have had to render primary health care and midwifery services, often with little or no special learning. Yet, many of these nurse-midwives have rendered excellent care to women in hospitals and clinics in both the rural and the urban areas. (For further discussion see 2.7.4.2).

1.2.2 THE CHANGE IN THE HEALTH CARE STRUCTURE

The National Health Care plan is based on the principles of equity and right to health. The aim is to improve the health of all South Africans by achieving equitable economic and social development. This includes the promotion of healthy lifestyles and the provision of accessible health care services. It is believed that every person has the right to achieve optimal health and that the state has a responsibility to provide resources necessary to achieve this. The means to achieving this end is the adoption of a primary health care approach in the restructuring of the health service. The plan "... embodies the concept of community development, and is based on full community participation in the planning, provision, control and monitoring of services" (African National Congress 1994a :19).

Therefore, consideration needs to be given to a curriculum which prepares graduands to work in a health care service which adopts such a philosophy. Primary health care demands practitioners who are capable of problem-solving, decision making and critical thinking. These concepts cannot be developed in a content-driven curriculum. They are processes which

need to be developed. Problem-solving requires that students learn to identify problems, to seek solutions and to identify the most appropriate solution. This process requires critical thought. This concept is not developed in a lecture-based, content-driven curriculum. Furthermore, the traditional content-driven curriculum is not consistent with community development and community participation, in that it does not actively seek to promote the health of the community. In order to promote the health of the community the curriculum should address the health needs and issues of the community. It should participate with the community in health promotion activities in order to encourage community responsibility for health.

1.2.3 FEMINISM AND WOMEN'S HEALTH

It was in the late 1960s and the early 1970s that feminism became evident in the United States of America (USA) and in the United Kingdom (UK) (Olesen and Lewin 1985). The movement brought the role of women in society to the fore and over the last 20-30 years efforts have focused on the need to bring women into full and equitable partnership in every domain of the society. This has resulted in the questioning of the woman's traditional roles in the society. Emerging from this analysis is a questioning of women's experiences as recipients of health care. Traditionally women's health care needs have been viewed and met within the confines of birth control and childbirth. McPherson and Waller (1997:1) state that women's health no longer simply concentrates on childbirth. They cite reasons for this as the rise in feminism, the increasing numbers of female doctors, the global nature of medicine and the increasing political power of women.

1.2.3.1 FEMINISM IN SOUTH AFRICA

The women's movement in South Africa has probably lagged behind that of the U.S.A. and the U.K., but there is an increasing force of women making a name for themselves in politics, business and in academia and more women are being accepted into the medical schools to study medicine. Currently the Speaker of the National Assembly is a woman, as is the Minister of Health and one quarter of the parliamentarians are women. Women in business

have united and have generated sponsorship for an annual Business Woman of the Year Award. In the academic arena women leaders are coming to the fore in their promotions to vice-chancellor of a university and deans of various faculties. At this university, of 209 students admitted into medicine in 1998, 110 or 53% were women. The statistics show that this has been the trend over the last four years. For the second, third , fourth and fifth years of study for medicine 56%, 54%, 49% and 58% of the classes respectively are women (personal communication).

South African women have shared the discrimination of their gender with women worldwide. Depending on one's culture, South African women have been discriminated against in education, nutrition and occupation. In some cultures education for girls is still not a priority, as the woman's place is perceived as being in the home where her responsibilities revolve around housework, cooking and child care. Depending on her socio-economic circumstances, housework may include fetching and carrying wood for the fire and water for household needs. Thus education is perceived as being wasted on her. The causes of malnutrition amongst women varies according to their culture and socio-economic circumstances. In some cultures it is traditional for the women to prepare the food, but they only partake of the meal when the men have had their fill. This often means that there is little or nothing left for them and what is left they give to the children. Other factors related to malnutrition are limited access to foods, dietary insufficiencies and cost.

In the workplace women have been regarded as cheap labour and have therefore been paid low wages. In order to supplement their income many women work overtime. In the workplace little attention has been given to working conditions and environmental factors that may influence a woman's health. Access to aspects such as protective clothing and health assessment has been limited. Furthermore, it is only in the last few years, that sexual harassment in the workplace has been acknowledged and procedures to combat this are now beginning to be put in place in most of the larger businesses and concerns. However, in the smaller businesses the problem is still prevalent. This problem extends to women in domestic

work. Other areas of discrimination in the workplace relate to salaries and the inequitable pay given to women as compared to men for the same work and the opportunity for development and promotion, where men are more likely to be promoted ahead of women irrespective of their capabilities for the task. Given the traditional and cultural beliefs of many of the ethnic groups, that a woman's place was in the home, women were not seen to have a role to play in public life. Financial control and policy making have not been considered to be women's work (African National Congress 1994b:77).

1.3 STATEMENT OF THE PROBLEM

The current nursing curriculum is fragmented and content driven. As a result there is content overload. Furthermore, with its emphasis on content and the use of high-tech tertiary care institutions for practical experiences in midwifery, it does not adequately prepare graduands for community health practice and for holistic care for women of all ages.

The university nursing department needs to provide an appropriate women's health curriculum for its own students and then to make its research findings known to the wider nursing education community. This particularly applies to the nursing colleges for whom it has the responsibility to control and maintain the standards of practice in women's health. This study is initially being developed for students in a university nursing programme.

1.4 RESEARCH QUESTIONS

Four questions may be posed:

1.4.1. What type of curriculum best prepares graduands to be able to meet the needs and provide support to women and in particular childbearing women?

1.4.2. What are the needs and the support required by childbearing women?

1.4.3. What are the perceptions of women and the midwives about the care rendered?

1.4.4 What type of graduate nurse is needed to meet these needs and perceptions?

1.5 PURPOSE OF THE STUDY

The current curriculum is university and hospital focused, both in its theoretical and practical components. The nature of the hospital practice is one of sophisticated technology, with little emphasis on the use of clinical skills. This has created a dependency in students who become passive practitioners with little or no faith in their own skills and abilities. As a result these practitioners are ill prepared for community practice, where they will frequently be required to work on their own. This will require practitioners who have developed clinical and management skills. The concept of primary health care cannot be learnt in tertiary care hospitals. Practitioners need to be able to recognise problems, to problem solve and to make decisions. The opportunity for this is limited in a traditional lecture-based curriculum. Students need to be given opportunity to work with and through problems and situations that reflect the practice setting. In order to develop the abilities to problem solve and make decisions, critical thinking needs to be developed.

The emphasis given to women's health in the National Health Plan requires that this be given emphasis in the curriculum. This requires that the four year curriculum be reviewed in the light of its content.

The purpose of this study, then, is to evaluate the current curriculum. The approach to this evaluation is to explore and describe the perceptions of the stakeholders, viz. women, students, registered midwives and clinical supervisors about midwifery education in particular. The results will be used to develop a curriculum based on process and outcome standards for four year degree nurses that will produce a nurse-midwife better able to meet the needs of women's health, beginning at a primary health care level.

1.6 OBJECTIVES OF THE STUDY

The objectives of the study relate to curriculum evaluation and development and therefore are to:

1.6.1. develop a conceptual framework for the curriculum evaluation and development

processes.

1.6.2 assess the needs of the community. This will be done by:

1.6.2.1 describing the perceptions of women in hospital and community settings;

1.6.2.2 identifying the perceptions of midwives regarding the needs of childbearing women and their role and function in that regard;

1.6.3 describe students' perceptions of the current curriculum. This will be done by:

1.6.3.1 determining the perceptions of students currently in the curriculum;

1.6.3.2 determining the perceptions of graduands regarding their preparedness for midwifery practice on completion of their degree.

1.6.4 obtain the perceptions of nursing supervisors regarding the midwifery curriculum and the beginning midwifery practitioner.

1.6.5 design a curriculum model for women's health, with emphasis on the childbearing woman, utilising the concepts of community-based education and problem-based learning.

1.7 STAGES IN RESEARCH METHODOLOGY

Before the study could begin clarification on the following issues was required:

- identification of problem and discussion of the nature of the problem
- the problem statement
- concept clarification and definition
- development of the conceptual framework.

This defined **stage one** of the methodology and was influenced by the literature reviewed. It resulted in the development of the conceptual framework.

In **stage two** of the process the research methodology was identified from the conceptual framework. The research methodology is based on a needs assessment using both quantitative and qualitative methodologies. Review of the literature continued and guided this process.

During **stage three** data were collected and analysed. Data collection was guided by t conceptual framework. Review of the literature continued in order to validate dings and provided a measure of control.

Stage four of the methodology was characterised by the development of the curriculum model. This stage was influenced by the conceptual framework and the findings of the study. Review of the literature provided a mechanism to ensure that the proposed curriculum was consistent with international trends in nursing education. The proposed curriculum model was subjected to peer review by a group of experts in order to validate the proposed curriculum model.

See Figure 1.1 for a diagrammatic representation of the research methodology and development of the study.

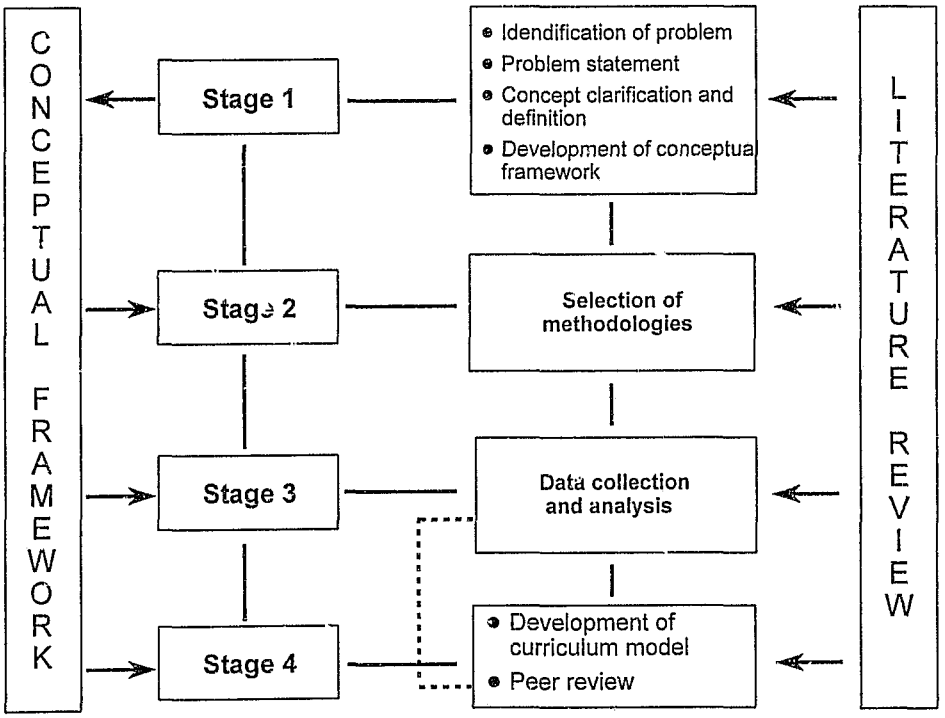


Fig 1.1 Diagrammatic representation of the development of the study

The four stages will be described in the following chapters. The content of these chapters is as follows:

Chapter one - introductory aspects of the study.

Chapter two - literature review of the core variables of the study, viz. Problem-based learning, community-based education and women's health.

Chapter three - the conceptual framework.

Chapter four - the research methodology.

Chapter five - the presentation of the findings and a discussion of the findings.

Chapter six - implications of the findings for nursing education and curriculum development.

Chapter seven - the suggested curriculum for women's health.

Chapter eight - the summary, recommendations, limitations and conclusions of the study in a series of reflections.

1.7.1 ANALYSIS OF THE DATA

The approach to the analysis of the qualitative data will be based on the eight steps suggested by Tesch (Cresswell 1994:155). This approach will be described in chapter four.

Quantitative data will be analysed manually and where appropriate will be subjected to bivariate analysis using the SAS version 6.12 package. Where appropriate data will be presented using tables, histograms and pie graphs.

1.8 KEY CONCEPTS

For the purpose of this study the concepts are defined as follows:

problem-based learning - refers to the use of problems / situations as the focus for teaching and learning.(A more detailed definition and explanation of this concept will be given in Chapter Two.)

community-based education - refers to a curriculum in which an appropriate number of learning activities take place in a balanced variety of educational settings in the community and in a diversity of health care services (Owen 1991). (A more detailed definition and explanation of this concept will be given in Chapter Two.)

women's health - this refers to women's health across the lifespan. It includes health needs and the factors which influence these needs.

childbearing - refers to the health needs of the woman who is in the process of bearing or nurturing a child, i.e. pregnancy, labour and the puerperium. It includes women in the 13-45 year age group.

undergraduate degree - refers to the four year basic degree in nursing which gives the graduand entry into the profession as a registered nurse (general, psychiatry and community nursing) and midwife.

perceptions - refer to the individual's interpretation and experiences of the topic under discussion.

1.9 CONCLUSION

In this chapter the background of the study has been described. Reasons for the research have been described and the research questions and objectives of the study have been developed and explained. The development of the research methodology has been outlined. The latter will be elaborated upon in Chapter Four. In chapter two the core concepts of the study, viz. problem-based learning, community-based education and women's health, are explored through the use of a literature review.

CHAPTER TWO

LITERATURE REVIEW

> No man can reveal to you aught but that which already lies half asleep in the dawning of your knowledge.
> (Gibran 1997:64)

In this chapter the central themes of the study will be discussed, viz. problem-based learning, community based education and women's health. An initial search was done by linking the key concepts of the study. This led the researcher to consult journals, books and experts in the relevant fields.

2.1 PROBLEM-BASED LEARNING

2.1.1 INTRODUCTION

Prawat (1989) states that most curricula emphasize factual and procedural knowledge at the expense of conceptual understanding. He contends that textbooks tend to perpetuate the problem through their superficial treatment of topics in order to cover a broad spectrum of content. This aspect is further entrenched by the fact that even the best curriculum material is adapted to fit practitioners views of teaching and learning. He goes on to say that a further obstacle to facilitating understanding is the belief that learning progresses hierarchically, i.e. from the simple to the complex, and in so doing to separate content from process. He states (1989:317) that "... more recent research ... stresses the importance of connections - of developing networks of knowledge." Prawat (1989:319) believes in teaching for understanding and that three factors appear to be significant here. These are that the instruction should be focused and coherent; it should be negotiatory in its interactive style and that it should be strongly analytic or diagnostic on the teacher's part. More recently, Barr and Tagg (1995) have described the changes taking place in undergraduate education. They

describe the change as a shift from an instruction paradigm to a learning paradigm. They argue (1995:21) that "the learning paradigm frames learning holistically, recognizing that the chief agent in the process is the learner."

2.1.2 PHILOSOPHICAL BACKGROUND

Problem-based learning (PBL) as a method of instruction is firmly entrenched in the rationalist tradition and is therefore strongly influenced by cognitive psychology. It draws on the philosophies of Dewey and Bruner. Dewey called for the fostering of independent learning in children and Bruner viewed intrinsic motivation as an internal force that drives an individual to know more about the world (Schmidt 1993:423).

Kneller (1971:89) states that "... logical and psychological order should not conflict but should go hand in hand..." Dewey equated the psychological and logical with process and product respectively. He viewed the psychological process as the means of understanding subject matter in its logical form. To him the latter is an ideal to be achieved and is not the starting point from which to proceed. Kneller (1971:89) quotes Dewey as saying that "the learning process is the progressive development of what is already experienced into a fuller and richer and more organized form, a form that gradually approximates the subject matter presented to the skilled, mature person."

Dewey formulated the concept "logic of enquiry". To him, logic of enquiry is both prescriptive and descriptive. It is prescriptive in that it recommends principles to follow and it is descriptive in the principles that are followed when enquiry is successful. Dewey stated that to enquire was to resolve a problematic situation, which he said took six steps. These steps are:

- All thinking is a response to a difficulty that cannot be overcome by instinct or routine.
- Dissatisfaction and the need to give significance to the matter results in the formation of questions to be resolved.
- Problem formulation leads to the seeking of information to solve the problem.
- Possibilities are evaluated against the consistencies of the facts at the individual's

disposal.

- The more likely suggestions are tested.
- Explanations to the problem are now justified on the basis of the information obtained (Kneller 1971).

Pragmatists, of which Dewey is one, believe that we comprehend things best by identifying and solving problems. Kneller (1971:25) writes that "according to the pragmatist, the teacher should construct learning situations around particular problems whose solution will lead his pupils to a better understanding of their social and physical environment." He goes on to say that the pragmatist considers the young person to be a natural learner because he \ she is naturally curious. Learning is greatest when the individual is stimulated to think about and to explore an issue. It is the teacher's responsibility to foster a spirit of enquiry. To promote a spirit of enquiry, the teacher should encourage the student to learn about what interests him and should encourage the student to be curious about subjects that matter. In this process the pragmatist rejects individual development at the risk of social exploitation. For Dewey utopia is the community "... built by people who have the courage to think independently and yet relate themselves to the group" (Kneller 1971:37).

2.1.3 BRIDGING THE GAP

Schmidt (1993:427) states that "problem-based learning was originally developed at the Faculty of Health Sciences of Mc Master University around 1965." Barrows, a neurologist, arrived at McMaster towards the end of the 1960's and became a major proponent of the approach.

Barrows states that "a wide variety of educational methods are referred to as problem-based learning" (undated :1). He goes on to state that these methods can address different educational objectives, but that the common denominator is the use of problems in the instructional sequence (undated :1). Schmidt (1993:423) attributes the role of problems as the starting point for learning to Dewey,"... who stressed the importance of learning in response

to, and in interaction with, real-life events." Dewey viewed knowledge as something which could not be transferred, but rather that had to be actively mastered (Schmidt 1993). Birch writes "...that problem-based learning provides a focused and structured approach to learning ..." (1986:73). In 1986 Boud wrote that it was increasingly being recognised that students have significant experience which should be drawn upon; that students do have views about what they want to learn; that they do not see knowledge in terms of bodies of knowledge, but in terms of capabilities to be developed; that learning should be meaningful at all times; learners are individuals who require assistance and support and that they tolerate didactic teaching because this is what they have been lead to expect from educational institutions. In addition, it is recognised that much of the subject matter taught is irrelevant and that there is lack of integration of subject matter (Schmidt 1983). It has been suggested that problem-based learning may meet some of Boud's considerations about learning and may help to overcome some of the problems experienced in the teaching of students for the health care professions. Engel (1991) views problem-based learning as a means of developing learning for capability rather than learning for the sake of acquiring knowledge.

2.1.4 DEFINING PROBLEM-BASED LEARNING

Scheiman, Whittaker and Dell (1989:11) state that "problem-based learning is an instructional method designed to allow the student to use a particular problem as a focus for the study of a variety of subjects." However, Albanese and Mitchell (1993:53) write that "defining what exactly constitutes PBL was a confusing and somewhat contentious task." They go on to state that the complexity of defining PBL is reflected in the fact that Barrows felt it necessary to develop a taxonomy of PBL types. Neame (1981) states that problem-based learning is the presentation of selected items of "trigger" materials which leads students to identify essential learning that they need to undertake. The learning will have components from every discipline which contributes information relevant to the case. Certain features distinguish it as an instructional method. These are:

- the use of problems or situations for students to learn problem-solving skills;
- that students identify their own learning needs;

- that the process is carried out through interaction with peers;
- that the role of the teacher becomes that of a facilitator who guides and probes, rather than providing solutions, and
- that the problem is presented prior to basic information being given.

From the above, it is clear that problem-based learning is a process. For the purpose of this discussion the process will be discussed under the following headings - the problem or situation and the tutorial process.

2.1.4.1 THE PROBLEM OR SITUATION

Albanese and Mitchell (1993) quote Walton and Matthews as stating that the essential characteristics of a PBL curriculum are the use of problems as a focus for learning basic science and clinical knowledge along with clinical reasoning skills in an integrated, rather than separate fashion. Barrows argues that learning is enhanced when it is organized around a problem (Albanese and Mitchell 1993). Prawat (1989) also emphasizes the organization of learning material, saying that the ability to draw on previous knowledge in new situations is influenced by how it is organized. He quotes Polya who states that this factor is even more important than the extent of one's knowledge.

Schmidt (1983:12) states that according to the information processing approach to learning there are three conditions which facilitate learning - these are the activation of prior knowledge, encoding specificity and the elaboration of knowledge. These conditions are based on the theory of cognitive learning which espouses deduction, logic and reasoning. Dewey believed that the learner had to master information. In order to do so, the learner has to activate available cognitive structures, or long term memory. Cognitive structures both influence the ability to understand new information as well as limit the extent to which new information can be understood (Schmidt 1993:423). Based on the three conditions which facilitate learning, Schmidt, in his earlier writing, (1983:15) states that attention must be paid to the characteristics of the problems being used. With reference to the principle of activating prior knowledge, Schmidt quotes Willems (1983:15) who states that a written problem will

only activate prior knowledge if it has the following features:

- it should consist of a neutral description of an event or set of phenomena that are in need of explanation in terms of underlying processes;
- it has to lead to problem-solving activity;
- it is formulated as concretely as possible;
- it should have a degree of complexity adapted to students' prior knowledge. If it is not sufficiently complex, students will not recognise it as a problem. If it is too complex, students may think that it is no use trying to solve it.

The second principle of encoding specificity is met if the problem has a close resemblance to problems that students will encounter in professional life (Schmidt 1983:15). To this end Schmidt quotes Barrows and Tamblyn and Neame who propose that problems that are used should:

- have the greatest frequency in the practical setting;
- represent life-threatening or urgent situations;
- have a potentially serious outcome and where intervention can make a significant difference to the prognosis;
- be those that are most often poorly managed by doctors in the community.

The third principle of elaborating upon knowledge is promoted in the group discussion (Schmidt 1983).

Given the above requirements that the selected problems should meet, Andrews and Jones (1996) quote Hafler who has discussed some of the difficulties encountered in writing scenarios. These are the amount of detail to include, where the data for the problems come from, i.e. actual patients, writer's experiences or hypothetical situations and how to ensure that the essential concepts of the course are covered in the problems. Hafler (1991:154-155) states that cases should have a central topic rather than multiple themes and that red herrings should be included for more advanced students. Hafler (1991) writes that "... the experience

of having been a tutor may be a potentially important aspect of selecting case writers, but further research needs to be done in this area." Hafler goes on to explain that tutoring provided writers with a better understanding of the students and of the relationship between the length of the case and the amount of time in the tutorial. In addition, the best cases were felt to be those written from personal and professional experiences, because writers were familiar with the patient and content could be selected based on their expertise. It was also found that real cases stimulate more interest than hypothetical cases. Hengstberger-Sims and McMillan (1993) concur that there are difficulties in writing problems. They state that not all the staff will have the skills or the interest to acquire the skills to write problems. Potential authors should be identified and nurtured. Other suggestions they offer are:

- writing workshops in which the skills of package writing and the development of the final product are explored through experiential learning;
- preceptorship - buddying an experienced writer with a neophyte has been found to be useful;
- support and maintenance of a strong core of writers to ensure quality and quantity of material;
- release of staff to facilitate the production of quality packages;
- base packages on actual case histories. To improve the quality of the package it is preferable that the writer has met and interviewed the client;
- consideration of local demographies and the health problems or needs which are specific to the region;
- consideration of the availability of resources;
- placement of the student in a specific role and context within the learning package - this is considered as important as it gives the student an opportunity to practise responses in the context in which they will be required to work on completion of their studies;
- making use of a selection of learning stimuli and merge several into one package;
- evaluation of the learning packages through peer review. To meet this need a peer review panel is useful.

Prawat (1989) states that it is important to know which concepts are troublesome for students when setting content priorities.

Problems may be presented in a variety of ways. Some of the suggestions include the written problem, an audio-visual presentation, simulated clients and computer assisted learning. Use has also been made of mystery stories and biographies which are culture appropriate. The written problem lends itself to being extended through the use of the health care professional's notes relating to the case, x-rays, laboratory reports, prescription charts and observation charts.

The use of the word "problem" for the package in the nursing discipline is not always appropriate. There are instances in health care where the client does not have a problem in the strict sense of the word, but the situation could be improved. An example of this is a pregnant woman who is experiencing a normal, healthy pregnancy. Her situation will lend itself to preparation for labour through ante-natal classes, requiring interventions from the midwife. As a result of this dichotomy the Australian schools of nursing, which use problem-based learning, prefer to use the term "situation" for the learning packages. Drinan (1991:317) states that "..., the term "problem" should be recognised to be limiting in itself. ... problem implies being reactive, when the focus may require proactivity ..."

Another variation on the presentation of the problem is that used by Alverno College in Milwaukee, where students do not always begin their learning with a problem. In the education of nursing students it is felt to be pedagogically sound for students to begin their learning with some concepts before working with actual problems. This approach is used because of the felt necessity to begin where the student is and because of the varied learning styles of the new students which need expanding and gradual diversifying (O'Brien, Matlock, Loacker and Wutzdorff 1991).

2.1.4.2 THE TUTORIAL PROCESS

The tutorial process focuses around small group discussion. The group consists of a number

of students and a facilitator. The tutorial process will be discussed using the concepts of the tutorial process, students and facilitator.

2.1.4.2.1 The tutorial process.

A variety of methods have been described and used to implement the tutorial process. Problem-based learning makes use of tutorials as opposed to lectures which are the more common form of instruction used in traditional curricula. Tutorials usually refer to small group discussion, but this is not essential to problem-based learning. This aspect will be enlarged upon in the section relating to students. The method of conducting the tutorials is also variable. McMaster University uses the three step approach, while the School of Nursing at the University of Sydney uses five steps. The University of Maastricht uses the seven step approach.

In the first meeting of a group of students, aspects which relate to group work will be worked through. This will be discussed in the following section (vide 2.1.4.2.2 p 24). When a problem is presented for the first time students have to be guided through the analysis of the problem. For the purpose of this discussion the seven step approach will be described. Schmidt (1983) has described the seven steps or the seven jump method as follows:

- clarify terms and concepts used in the problem which are unknown. Schmidt suggests making use of group members' relevant knowledge or a dictionary, as ways to do this. Clarification may also mean reaching consensus about the meaning attached to a term.
- define the problem. This requires that the group as a whole reach an agreement on which interrelated concepts need explanation.
- explain the problem. To do this students may need to peruse the problem again. This allows them to develop ideas or suppositions about the problem based on their prior knowledge or on rational thought. This is a period of brain-storming.
- arrange the explanations systematically. This serves as a summary and structures the product of the problem analysis.
- formulate learning goals.

- attempt to fill gaps in knowledge through individual self study. This is not limited to the literature. Information and knowledge may be gained through audio-visual material, experts in the field and community resources.
- share findings with the group. In this group, findings are not only shared, they are also tested, corrected where necessary and supplemented. At this stage more questions may be asked. Should this situation occur the process goes back to the fourth step and the students strive for deeper understanding of the problem. (See Annexure A for the "Seven Jump").

Using this approach to the problem may vary the number of tutorials required to deal with it, depending on the size of the problem or the number of learning goals identified. More recently, Mandin, Jones, Woloschuk and Harasym (1997) have proposed the use of schemes in the problem-solving process. They state that methods for teaching problem-solving cannot be based on the assumption of a universal, generic process. In their opinion the use of schemes for both learning and problem-solving, provides the advantage of combining the creation of a knowledge structure and a search-and-retrieval strategy into a single operation. They (1997:176) state that experts use a scheme-driven strategy, but revert to hypothetico-deductive reasoning when the reasoning is outside their expertise. They may solve problems without a search strategy, by making use of pattern recognition. In the course of the tutorial, students in problem-based learning make use of a "search-and scan" method of enquiry (1997:177). At Calgary University (Mandin et al 1997: 177) use is made of a scheme-driven mode of enquiry. The method of analysis described above is utilised, but additional clinical cases are introduced in the same presentation. In the tutorial students distinguish how one case differs from another. They (1997:177) state that "since the same scheme is utilized for both the inquiry process and the organization of the knowledge just acquired, the problem-solving process reinforces the retention in long-term memory of the organization of the knowledge relevant to the specific problem. Consequently, that knowledge is learned, maximizing relevancy and minimizing information overload." They go on to say that the scheme-driven approach serves as a "road-map" for the student, in comparison with the search-and-scan

approach which involves the testing of a number of hypotheses.

2.1.4.2.2 The students.

Problem-based learning is student-centred learning. Students are encouraged to take responsibility for their learning. One method of encouraging this is through small group learning and discussion. Prawat (1989) refers to this as negotiation.

The advantages of small group learning have been listed by Walton and Matthews (1989:550) as follows:

- students learn that they have to actively do their share;
- communication skills are improved;
- students learn to respect the views of others;
- they experience the satisfaction of contributing towards the group;
- they learn the ability to take and give criticism without offence being caused, and
- an effective tutor imparts important role model aspects.

In addition to the above, Prawat (1989) says that this provides opportunity to "enculturate" students into the functioning of the various disciplinary groups.Closely associated with this is Neufeld and Barrows'(1974:1044) statement that it gives the student opportunity to develop interpersonal skills and to develop an awareness of his own emotional reactions. It provides opportunity for self-evaluation and peer evaluation. Students have been found to develop a sense of responsibility for the learning progress of group members. Taking responsibility for one's own learning also requires a role change on the part of the student. Not only must the student develop certain skills, but also a different attitude towards learning (Little and Ryan 1988:34).

According to Creedy, Horsfall and Hand (1992:729) the student-centred approach requires a positive regard for students and equality with the facilitator. They regard genuine communication as the basis for positive regard and equality in the classroom and clinical setting as necessary to empower students to take control of their own learning. Prawat (1989:323) quotes Barnes who says that valuing students contributions is the first requirement for successful group work and it may form the basis for genuine communication. In order to

promote equality in the learning situation it is essential that the group members develop and abide by an agreed set of group norms. Norms should be set to deal with issues such as late-comers, the use of offensive language in the group, those who do not participate or carry out the tasks set for the session and absenteeism. Thomas (1997:325) identifies key attitudes which aid group functioning. These are positive attitudes to the group, positive attitudes towards interaction, readiness to be critical at the right time and in the right way. Thomas (1997) goes on to quote Kowitz and Knutson who found that cohesive groups communicate with each other more frequently, exert more influence over each other, accept more responsibility for group tasks and accomplish more group goals, provided that there is a norm of productivity.

The size of the group may also influence communication. If the group is too large it may intimidate introvert personalities and prevent them from actively participating in the discussion. If the group is too small then real discussion cannot take place. McMaster School of Nursing proposes six students to one facilitator, while Macarthur School of Nursing proposed 12-15 students to one facilitator. However, due to government restrictions they were forced to increase the size of the groups to 25. Groups of up to 60 students to one facilitator have been found to be manageable and successful (personal communication). Research has demonstrated that there is great scope for misunderstanding in groups. Therefore strategies to reduce misunderstanding should be employed. These are clear communication with frequent restatement of ideas to maximize understanding, specific communication and the avoidance of generalizations (Thomas 1997:325).

2.1.4.2.3. The facilitator.

Because problem-based learning is student-centred, the role of the teacher of imparting knowledge must change to one of guiding the acquisition of knowledge. The teacher's role therefore becomes that of a facilitator. Silins and Murray-Harvey (undated:247) state that "the beliefs and values of a PBL facilitator with regard to students taking charge of the learning process are crucial here." Creedy, Horsfall and Hand (1992) also see the facilitator as having

an empowering role, while Wilkerson and Hundert (1991) view the facilitator as a partner in the learning process. Neufeld and Barrows (1974:1044) describe the requirements of a tutor as follows:

- must understand the general goals and methods of the programme;
- be skilled in managing small-group interaction;
- be able to help the group become gradually more responsible for its own activity and more mature as a learning resource;
- be capable of coordinating effective and meaningful evaluation, and
- himself be an example of self-directed learning and problem-solving.

To the last point Wilkerson and Hundert (1991:163) add that the facilitator is vulnerable - admitting when they do not know.

Little and Ryan (1988:33) state that " the facilitator role demands an ability to help students develop skills in critical thinking and problem-solving\reasoning, self-directed learning and self-evaluation." Crucial to this is the facilitator's questioning technique and ability to challenge. They state that questions must be structured in such a way that students are required to explain how they reached their conclusions, to think critically about another student's comments and to evaluate their problem-solving\reasoning processes. Feedback at the Macarthur School of Nursing and Health Studies demonstr ted that staff should have the opportunity to experience facilitation under simulated conditions before they undertook sessions themselves (Little and Ryan 1988). This concurs with Wilkerson and Hundert (1991) who write that new tutors report that two activities are influential in their development as problem-based tutors. Firstly, the opportunity to participate as a learner in a tutorial with a skilled tutor and secondly, the opportunity to be observed while interacting with their tutorial group.

According to Dolmans, Wolfhagen and Snellen-Balendong (1994:370) attention needs to be paid to the following four factors:

- formal requirements that should be satisfied in order to fulfil the tutor role;

- how a faculty dialogue can be stimulated;
- how a reward system can be designed, and
- what kind of remedial teaching activities can be organized as part of a faculty development programme.

With reference to the requirements for the tutor role they feel that the tutor should have had at least two years in the school; that each tutor is obliged to have attended a tutor training programme and that the tutor should work in a department whose discipline is related to the subject matter covered in the course. The results of the tutor evaluation questionnaire form part of the reward system, in that they are used for tenure and promotion decisions. Tutors who perform badly may also be disqualified from particular educational roles, such as that of a course coordinator.

There has been a fair amount of debate as to whether the facilitator should have knowledge about the subject matter of the problem. Neufeld and Barrows (1974:1045) state that nonexpert tutors have found that they can update their knowledge in an area while working with students. This allows them to maintain a perspective on problems in the health field and on new knowledge. They also report sharing the students' excitement of exploring and discovering new ideas. Eagle, Harasym and Mandin (1992) quote Barrows who sees the ideal as the tutor having expertise in both the subject and the tutoring process. Should this not be possible, he sees the next best as the tutor who has tutoring expertise. This is because he sees the tutoring skill as being the backbone to small group teaching. However, Prawat (1989:319) states that there is a clear relationship between what teachers know about content and the depth of understanding they are able to promote in students. He goes on to say that "..., a good grasp of what ideas are the most central to the discipline and how they relate to each other bears a necessary if not sufficient relationship to conceptual level teaching." Silver and Wilkerson (1991) found that tutors with content expertise tended to be more directive in the tutorials and that tutor to student exchange predominated with less student to student discussion. They warn that while this may harm the ability to produce self-directed learners, putting a group of students and a tutor together with a problem to discuss does not ensure that

students will learn to guide their own learning. Prawat (1989) concurs with this. He says that one of the most important skills appears to be the teacher's ability to structure discourse in order to promote knowledge organization and awareness in the students. Eagle et al's research (1992) supports Barrows' views. However, in the case of a nonexpert tutor they state that specific actions should be carried out. These are that the tutor:

- is clear on the course goals and case objectives;
- studies the clinical problem represented by the case;
- talks to other tutors who are experienced with the case, and
- consults with faculty members who are experts in the case.

More recently Moust (Schmidt and Moust 1995) has stated that cognitive congruence is a necessary condition for tutors to be effective. He goes on to state that both subject matter expertise and interpersonal qualities are necessary conditions for cognitive congruence to occur. They conclude (1995:713) that effective tutoring seems to imply "... the possession of a suitable knowledge base with regard to the topic under study, a willingness to become involved with students in an authentic way, and the skill to express oneself in a language understood by students."

Thus it can be seen that in problem-based learning the learner and teacher assume different roles from those in the traditional curriculum and the subject matter is presented in a style which favours discovery and active learning rather than passive learning which is the trade mark of the traditional curricula. Mpofu, Das, Murdoch and Lanphear (1997:330) quote Gijselaers and Schmidt who state that it is important to have a combination of factors to facilitate learning during PBL. They stress the importance of the activation of students' prior knowledge; good quality problems; a meaningful context; that the tutor shows an interest in the students; suitable group functioning and a well structured student guide book.

2.2 A CRITIQUE OF THE VALUE OF PROBLEM-BASED LEARNING: ITS ADVANTAGES AND DISADVANTAGES AS DEMONSTRATED IN THE RESEARCH.

Some of the qualities and attributes which have been linked to problem-based learning are the development self-directed learning, critical thinking and problem-solving skills, the use of relevant and usable knowledge, ability to address the needs of the learner, the facilitation of integration of knowledge and learning in context. Concerns raised relate to superficial versus deep knowledge and the costs of such a curriculum in terms of human and material resources. Another concern raised in relation to problem-based curricula relates to the nature of group learning and the graduands ability to work independently after graduation. These factors will be considered independently.

Problem-based learning is in its infancy in Africa and therefore the studies discussed below, refer to research undertaken mainly in the Netherlands, Canada, New Mexico and Australia where problem-based learning has a longer history. While Egypt has promoted problem-based learning in its medical curriculum, it would appear that most of their evaluative research has been in the area of community-based education.

2.2.1 SELF-DIRECTED LEARNING

This concept is considered to be essential for health care professionals if they are to take cognisance of changing health care needs, keep up with new knowledge and be able to change their performance skills accordingly. Boshuizen, van der Vleuten, Schmidt and Machiels-Bongaerts (1997:115) give three reasons for promoting self-directed learning. These are that students know best what they know and do not know and therefore what subjects need attention, that students should be allowed to pursue subjects they are interested in, at the particular time and that students will also choose the media they want to use for learning. Neufeld and Barrows (1974) argue that to be a self-directed learner necessary skills must be developed during the formative years. They go on to state that self-directed learning includes learning concepts such as learning to manage information, efficient reading, effective use of

study outlines, journals, texts and the library. Problem-based learning facilitates self-directed learning through the analysis of the problem and the identification of learning goals. Learning goals related to the problem can be broadened to suit the student's personal goals and future career path. Neufeld and Barrows (1974) see self-evaluation as a component of self-directed learning. This view is supported by O'Brien, Matlock, Loacker and Wutzdorff (1991) who state that when it became evident how self-assessment develops over time and how important its contribution is to students' development of autonomy as a learner, they found strategies to build it into the curriculum as a developing ability. However, Nolan and Nolan (1997b) state that it appears that the skills of self-direction need to be cultivated and fostered. They go on to suggest that a change in the teacher's role towards that of a facilitator and a change in the student-teacher relationship to one of a co-learner help to promote skills in self-directed learning. Iwasiw (Nolan and Nolan 1997b) argues that total self-direction is not a relevant model for nurse education and she offers the alternative concept of freedom within boundaries.

More recently, Kaufman and Mann (1996) have compared the perceptions of students at a Canadian university in a problem-based curriculum with those in a conventional curriculum. There were 73 students in the problem-based curriculum and 72 students in the conventional curriculum. Students were asked to rate twelve curriculum features on a nine point Likert scale. Students in the problem-based curriculum rated courses significantly higher ($p<.001$) on eleven of these features which described higher level thinking, managing information, stimulating self directed learning and overall satisfaction.

2.2.2 CRITICAL THINKING

Central to the argument here as to whether problem-based learning produces critical thinkers is the question "What is critical thinking?" From the literature it would appear that this concept has met with difficulty in attempting to define it and indeed whole texts have been devoted to this concept. Brookfield (1987:7) lists the components crucial to critical thinking as follows:

- identifying and challenging assumptions;

- challenging the importance of context;
- imagining and exp oring alternatives, and
- imagining and exploring alternatives leading to reflective skepticism.

Watson and Glaser (Shin 1998) define critical thinking as a composite of attitudes, knowledge and skills. Relating these to the practice of nursing it can be argued that these concepts are basic to the expected behaviour of professional nurses.

Neufeld and Barrows (1974:1042) state that in the tutorial group critical thinking can be encouraged. The tutorial group allows for arguments to be developed, for ideas to be built on, for the pooling of information and for strategies to be developed. They go on to state that "critical thinking (problem-solving) ability can be observed in tutorial or individual discussions and in "problem write-ups" (1974:1046). However, Sternberg argues that teaching critical thinking skills in one context, does not ensure their transfer to another context (Bethune and Jackling 1997).

The need to produce critical thinking nurses has been described by Jacobs, Ott, Sullivan, Ulrich and Short (1997). They state that to be able to challenge health care settings, to cope with rapid advances in technology and science, the growing body of nursing knowledge and the effects of the economy on health care, nurses need to be able to think critically. Krichbaum, Lewis and Duckett (1997:172) identify three reasons why nursing education needs to give consideration to critical thinking. These are that:

- one of the hallmarks of a professional discipline is that there is a unique body of knowledge and ongoing knowledge development. Intellectual curiosity and critical thinking are essential to knowledge development.
- professional practice requires one to evaluate situations and apply knowledge from the discipline and related disciplines in each unique clinical situation that arises. A professional must be able to modify guidelines to fit a particular situation.
- because of the importance of critical thinking to the discipline of nursing, nurse educators must attempt to develop it in their students.

It can be further argued that effective professional nursing involves decision-making. Shin (1998) states that critical thinking ability and clinical decision-making are closely related.

2.2.3 RELEVANT AND USABLE KNOWLEDGE

Discussion of the previous two concepts has raised the issue of the growing body of knowledge. It is also acknowledged that much of what is taught is not relevant (Maddison 1978). Andrews and Jones (1996:357) make the point that for nursing, a practice profession, there is a fundamental need to relate theoretical concepts to the clinical reality. The use of problems as a strategy for learning helps to focus learning and the careful selection of problem scenarios facilitates the use of knowledge. Neufeld and Barrows (1974:1044) state that "..., it is the use of information in the solution of problems that is encouraged." Factors which should be considered in the selection of problems have already been discussed. However, Boshuizen et al (1997:120) found that sixth year students in a problem-based learning curriculum at Maastricht University, may have behavioural science knowledge, but did not apply it in clinical reasoning.

2.2.4 PROBLEM-SOLVING SKILLS

Norman and Schmidt (1992:564) have reviewed several studies which have looked at students ability to problem solve. They conclude that "the issue of the effect of curriculum on "problem-solving skills" may well be viewed as a moot point, since the very existence of problem-solving skills can be challenged." They admit that there is a need for further research in this area, but this is dependent on better measures. Despite this characteristic being seen as a desirable outcome of problem-based learning, it does not appear to be have been given much attention in the literature. This may be due to the difficulty in measuring it objectively.

2.2.5 ADDRESSES THE NEEDS OF THE LEARNER

The needs of the learner can be described as preparing an individual for practice in a health care profession, about which she has limited knowledge. The learner does, however, have some life experiences on which to build. This means that each learner enters a programme at

a different level. The traditional curriculum pays little or no regard to this, while the problem-based curriculum allows the student to "back track" and acquire information necessary to the understanding of the problem and its concepts before exploring the concepts themselves. It also allows the student who has a particular interest in the problem to research and explore the concepts more extensively. Cleave-Hogg and Rothman (Lancaster, Bradley, Smith, Chessman, Stroup-Benham and Camp 1997) have implied that a supportive medical school learning environment promotes student achievement. Lancaster et al (1997) compared students in three different curricula in two universities in South Carolina. There were 56 students in a problem-based curriculum, 258 in a lecture-based curriculum and 27 in a traditional layered curriculum. They found that students in the problem-based curriculum felt that the learning environment provided a more meaningful learning experience, more flexibility, allowed exploration of special interests, was more nurturing, encouraged more student-student interaction and provided a more positive emotional climate than they had experienced prior to PBL.

Laschinger and Boss (1984:380) have studied the learning styles of nurses and suggest that "knowledge concerning the preferred ways of learning of nursing students may be useful in the selection of teaching-learning strategies in nursing education. More recently, Haislett, Hughes, Atkinson and Williams (1993:68) researched the learning styles of students in a Baccalaureate Nursing programme in South Carolina, U.S.A. Their sample comprised 100 students in an introductory nursing course in the first semester of the nursing curriculum. They found that the students who achieved higher grade points were those "... who relied on such reflective-observation preferences as understanding the meaning and implications of ideas and situations, appreciating what is presented to them from different points of view, and relying on their own thoughts and feelings to form opinions." Those who focused on concepts and a scientific approach to problem-solving also did well.

2.2.6 FACILITATES THE INTEGRATION OF LEARNING AND LEARNING IN CONTEXT

Traditional nursing curricula have tended to be content-oriented and objective-driven (MacIntosh and McGinnis 1997). As a result students have experienced difficulty in understanding the relevancy of some of the content to their courses. Problem-based learning facilitates the integration of learning by allowing the student to study the problem from every point of view. Such an integrated approach results in the student encountering certain concepts several times during her learning experiences (Neufeld and Barrows 1974). Problem-based learning provides a structured and focused approach to learning (Birch 1986). By creating contextual learning opportunities the three conditions that facilitate learning can be enhanced, viz. the activation of prior knowledge, encoding specificity and the elaboration of knowledge. Kelly (1997:157) quotes Weinstein and Van Meter Stone who found that models of education that focused on increasing knowledge did not achieve their goal. "They wrote that the difference between a novice learner and an expert learner is not simply that an expert learns or knows more, but that the expert has organized and integrated the knowledge better, using more effective and efficient strategies for accessing and using knowledge."

2.2.7 SUPERFICIAL VERSUS DEEP KNOWLEDGE AND DEPTH VERSUS BREADTH

A concern expressed of problem-based learning relates to the depth of understanding with reference to the basic sciences. Albanese and Mitchell (1993) reviewed ten studies that looked at student scores in some type of basic science examination. In six of the ten studies scores of students in conventional curricula were higher than those of students in PBL curricula. They go on to review seven studies which looked at clinical outcome criteria. In this instance PBL students scored higher in five of the seven studies. West et al (Kaufman and Mann 1997) suggest that primary care experience can favourably influence students' attitudes toward the basic sciences. Kaufman and Mann (1997) assessed attitudes of students at a Canadian university towards the basic sciences and found that attitudes were more positive at the end of two years of a preclinical PBL curriculum, compared to those of students in a conventional,

lecture-based curriculum. In this study, there were 72 students in the problem-based curriculum and 52 in the conventional curriculum.

Kolb believes that there is a close relationship between how individuals learn and the strategies they use to solve problems (Andrews and Jones 1996). Studies have shown a difference in the way that students in a problem-based learning curriculum study. They have been found to be more likely to study for meaning and less likely to study for reproduction; less likely to use memorization and more likely to use conceptualization as a learning method. They have also been found to make greater use of libraries and be more likely to attend formal instruction sessions, make more use of textbooks, journals and informal discussion with peers and staff (Albanese and Mitchell 1993). However, despite these qualities, research from McMaster University suggests that graduands tend to practice medicine in ways that cost more per patient and appear to have difficulty in making a diagnosis (Albanese and Mitchell 1993:67). Newble and Clark (1986) compared the learning styles of students in a traditional medical school with students in an innovative school. The total sample was 491 students. When students were compared in four categories, viz. meaning orientation, reproducing orientation, achieving orientation and styles and pathologies, students from the innovative school scored significantly higher in meaning orientation than students from the traditional school. In the reproducing orientation students from the traditional school scored significantly higher. In the achievement orientation category there was no significant difference and in the last category - styles and pathologies - students from the traditional school rated themselves significantly higher than those from the innovative school on operation learning. They state (1986:272) that these findings show "...that the students in the problem-based school appear to have an approach to studying that closely approximates the aims of most medical schools." They caution that this is far from ideal.

Pinto Pereira, Telang, Butler and Joseph (1993) report that in their experience students expressed difficulty in knowing the depth of knowledge expected of them. Students at McMaster University identified the lack of precise definition of core material as a deficiency of the curriculum (Albanese and Mitchell 1993). Andrews and Jones (1996) concur with this

finding. In their case study of eleven fourth year nursing students in Wales, they found that students had difficulty attaining the knowledge level expected of them; identified a large volume of knowledge, but found it difficult to determine the depth; had difficulty in assigning relevance to the information; crucial literature was not obtained and on occasion discussion remained at a superficial level. They state that it is possible that lack of depth of knowledge may relate to other teaching methods as well, but in the case of problem-based learning it is more evident because the teacher takes on a less participative role and therefore it is more easily identified. Albanese and Mitchell (1993:73) warn that because a problem could lead to discovery of content material, there is no guarantee that students will discover it. In order to overcome this potential problem they suggest that problems should be used which will lead students to the content that facilitators want them to master thoroug' and that is most important to students in their clinical years.

Norman and Schmidt (1992) have reviewed several studies which have looked at the students ability to recall information. The results of these studies may be summarised as follows:

- students in a problem-based course showed no difference in short-term recall, but a significant advantage in long-term recall (Martensen and colleagues:1980);
- immediate knowledge of students in a problem-based course was lower, but their forgetting curve over a two year period was essentially flat (Eisenstaedt:1990);
- students' initial learning may be poorer, but they process the information learned more extensively (Tans and colleagues:1986).

2.2.8 COSTS OF A PROBLEM-BASED CURRICULUM

A number of costs need to be considered in a problem-based curriculum. Some of these are time constraints of faculty and students, the availability of support personnel, material supports such as books and printing facilities and the availability of venues for small group work. Albanese and Mitchell (1993:70) state that PBL requires less faculty time if the number of groups is smaller than ten. Shahabudin (1987) found that it takes more time to cover the same content in PBL. That there is additional cost in terms of material and physical resources cannot be denied.

2.2.9 ABILITY TO PRACTICE INDEPENDENTLY

The question has been raised as to whether students become so dependent on small-group interaction during their studies as to prevent them from functioning independently on completion of their studies. Tolnai found that graduates from a problem-based learning curriculum were less likely to practice in rural areas, be in solo practice and to read journals than students from a traditional curriculum. It is possible that these students found rural practice isolating in terms of peer contact (Albanese and Mitchell 1993). Conversely, small group work may be incorporated into the curriculum as a means of promoting team work in the clinical situation.

Berkson (1993:585) argues that "the graduate of PBL is not distinguishable from his or her traditional counterpart. The experience of PBL can be stressful for student and faculty. And implementation of PBL may be unrealistically costly."

Santos-Gomez, Kalishman, Rezler, Skipper and Mennin (1990) evaluated graduands from a conventional track (sample of 62) and from a problem-based track (sample of 39) at the University of New Mexico. Three ratings were used - from a doctor-supervisor, a nurse and from the graduand him\herself. Graduands from the problem-based track scored higher in the areas of health care costs, communication with patients and patient education, while graduands from the conventional track scored higher in the knowledge dimension. In addition, Mennin, Kalishman, Friedman, Pathak and Snyder (1996) report that graduates from both tracks at the University of New Mexico, resembled each other in the reasons that motivated their learning. However, the problem-based track graduates (33 respondents) felt that they were best prepared in the areas of teamwork, clinical reasoning, diagnostic skills and doctor-patient relationships. The conventional track graduates (87 respondents) felt that they were best prepared in history-taking skills, physical examination skills and interviewing skills. Contrary to Berkson, Moore-West, Harrington, Mennin, Kaufman and Skipper (1989) report that "... a student-centred, problem-based approach may more effectively help students handle the stress associated with mastering a large body of information and coping with distressing situations such as those encountered by the practising physician."

In a recent study done at Moi University in Kenya, Rono (1997) asked medical students what they perceived to be the challenges and limitations of problem-based learning at that institution. The sample comprised of five randomly chosen students from each of the six years of study. The responses could be divided into four categories - tutors, students, learning objectives and learning resources. Problems associated with the tutor included inadequate preparation for the tutorials, inexperienced tutors and tutor domination. Student associated problems included domination of the group by individual students, difficulty in expressing oneself in a group and laxity in getting tasks completed in time. Students also felt that when a student chaired a group, ineffective chairing could be problematic. With reference to learning objectives, students felt that they were sometimes over-ambitious in raising learning objectives. It was also felt that there may be discrepancy between student and faculty objectives. Problems in the learning resources related to the shortage of resource persons and resource materials.

Some of these findings are consistent with those of a study done in a nursing department at a South African university. Cassimjee and Brookes (1998:99) report on the concerns of 24 second year students in a Baccalaureate Nursing programme. They state that " ... staff resources proved the greatest problem to most students. ... Lack of time was shown to be the second most serious problem." In addition, students also had difficulty in accessing peers as resources. It was interesting to note that 12 % reported having too much free time. Group work was another area of concern. Some students felt stressed by the fact that groups did not learn the same content, while others voiced concern that not all members of the group worked equally hard. It was felt that some "did not pull their weight." In the initial questionnaire, eight students felt that the course involved too much work. In the follow-up questionnaire, however, none had this concern.

2.2.10 CONCLUSION

Thus in developing and implementing a problem-based curriculum consideration needs to be given to small group learning and the group process. A central feature of small group work

is dialogue and the sharing of information. In these groups students are encouraged to take risks in thinking creatively and critically. This requires a safe and trusting environment. Students need to master the tutorial process through the use of the Seven Jump approach. Consideration needs to be given to the change in role for the teacher, to that of facilitator and co-learner. The facilitator needs to be creative in encouraging self-directed learning and problem-solving skills in the learner. Consideration must be given to the facilitator's knowledge. The trigger material used to develop these qualities in the learner needs to be given serious consideration. It should be based on the real world and be contextual, but at the same time it must address the learning needs of the student. Furthermore, it should promote the integration of knowledge. Students must be guided to attain the minimum depth of enquiry demanded of the problem and through reflection on prior learning be guided to an understanding of what is meant by core knowledge. In developing skills in self-directed learning students need to develop an awareness of sources of learning materials. In addition, they need to develop skills in accessing this information and in managing information. For many students this will require developing efficient reading skills. All of these aspects must be given due consideration when developing a problem-based curriculum.

2.3 CHANGES IN THE SOUTH AFRICAN PRIMARY AND SECONDARY EDUCATION SYSTEM.

In 1997 the Minister of Education, Sibusiso Bengu, announced a new curriculum for primary and secondary education. In his foreword to Curriculum 2005 (1997) he states that the new curriculum is "... based on the ideal of lifelong learning for all South Africans." He goes on to state that "..., the new curriculum will effect a shift from one that is content-based to one which is based on outcomes. This aims at equipping all learners with the knowledge, competencies and orientations needed for success after they leave school or have completed their training."

The outcomes-based curriculum incorporates the concepts critical thinking, rational thought and deeper understanding. Its philosophy incorporates the development of lifelong learners

and caring individuals and a system that is people-centred. Outcomes-based education seeks to promote an empowerment-oriented approach to learning.

The curriculum consists of eight learning areas that have been identified to meet the community's needs and to therefore foster its development. Education is viewed as a joint responsibility of the State, the community and the private sector. The involvement of parents is seen as essential to developing a culture of lifelong learning.

Assessment will be on a continuous basis and will incorporate strategies such as peer and self-assessment.

If primary and secondary education is moving in an outcomes-based direction, it is essential that tertiary education change as well. The characteristics of outcomes-based education have been described, inter alia, as being learner-centred, focused on life skills and context, publicly defined and future oriented (personal communication). It is clear that outcomes-based education and problem-based learning are built on a similar philosophy and aim to produce similar characteristics in the learners.

2.4 COMMUNITY-BASED EDUCATION

South Africa's National Health Plan has adopted the primary health care approach as its underlying philosophy for the restructuring of the health system. Up until 1994 when the African National Congress came into power, the health system was fragmented in its approach to care, resulting in duplication of some services at the neglect of others. There was, and still is, a strong divide between the public and private services in terms of technology and the approach to care. The preparation of health care professionals was mainly for hospital based care. Furthermore their education did not prepare them for work in the rural areas. Thus the current education of health care professionals is inadequate for a health structure based on the primary health care philosophy.

This phenomenon is not unique to South Africa. An American study (Bryan, Bayley, Grindel, Kingston, Tuck and Wood 1997) quotes Ceslowitz and Loreti who found that sources of anxiety for nursing students were being expected to function in unfamiliar surroundings and having to interact with the patient and family in the home. Other concerns noted by these students were the great responsibility placed on the nurse as a teacher, the scope of assessments required and the responsibility of precise documentation. Positive aspects related to the time spent with each client, the freedom to be creative and the opportunity to work with families holistically.

Another issue which relates to the preparation of nurses for primary health care is that of teamwork. Wiles and Robison (1994) write that the advantages of teamwork have been described in the literature from the 1970's. They go on to state that it is seen as an effective method of providing care because it leads to high levels of communication and it provides opportunity for health promotion. In their study in Southampton England, they found that nurses perceived teamwork as being part of a team in which the doctor took the leadership role and that midwives and health visitors were the least integrated into the team.

In 1991 a World Health Organization report on changing medical education stated that one of the important aims of education is to serve the people. It goes on to state that "..., the training institution would be expected to use its resources and potential for the benefit of the community. By doing so it would accept a shift of emphasis in teaching, research and service, from disease to health, from the hospital to community-based settings, from cure to prevention and promotion, and from solo practice to team work" (1991a :11).
Mennin, Friedman and Woodward (1992) write of the politics of programme evaluation. They ask the question, Who are the consumers, and who are the stakeholders of programme evaluation? To this they state that the stakeholders are the students, academics, other staff, administrators, community people, government, funding agencies and, most importantly, the public. They go on to say that each group has its own specific information needs.

Jaeger-Burns (1981:173) states that "although there is a relatively high level of espoused commitment to primary health care, this commitment does not appear to be adequately translated into primary health care nursing programmes." She goes on to say that nurse educators are inexperienced in primary health care and that students obtain little clinical experience in the community. She states that the traditional approach to community health training has meant that health care education has remained didactic rather than clinical. In addition, she notes that nursing is not collaborating intersectorally. Chamberlain and Beckingham (1987:159) concur with Jaeger-Burns. They state that while the World Health Organization remains convinced of the nurses key role in reorientating health systems to primary health care, "... the thread of primary health care as a philosophy is not always seen throughout the curriculum." Mundt (1997) calls for an evaluation of clinical learning experiences in the changing health care environment. She (1997:311) quotes Packer who "... notes that traditional models of clinical experience continue to exist in spite of significant changes in health care."

Thus it would appear that nurses are not being prepared for primary health care and yet they are seen to be the key health professionals in such a health care structure.

2.4.1 DEFINING COMMUNITY-BASED EDUCATION

Two concepts need to be addressed here - these are community-based education and community-oriented education. Some professionals use the terms interchangeably, others distinguish between the two and others see them as complementary. In Egypt, Refaat and Nooman (1989:8) see the two concepts as complementary. They define community-based education as "involving the community throughout the entire educational experience as an important environment in which learning takes place." Community-oriented education they define as "education focused on population groups and individual persons which take into account the health needs of the community." Owen (1991) concurs with the latter definition and of community-based education states that a curriculum can be considered to be community-based if an appropriate number of learning activities take place in a balanced variety of educational settings in the community and in a diversity of health care services at

all levels of care.

2.4.2 CHARACTERISTICS OF A COMMUNITY-BASED CURRICULUM

Nooman (undated:68) states that a community-based curriculum should:

- reflect the primary health problems and needs of the community;
- promote a community orientation from the outset and throughout the curriculum;
- foster a holistic approach to health care;
- foster a high level of health education to the public designed to promote health and the prevention of disease;
- promote students' problem-solving abilities;
- ensure valid assessment of the competencies that students should acquire from community-based education, and
- promote the health team approach.

2.4.3 UNIVERSITY EDUCATION

If the above are the characteristics of a community-based curriculum, then universities approaches to teaching and learning will have to change. Bryant (1993:217) puts it this way "universities and medical schools must leave their cloistered environment. The time has come for them to venture out into the world and grapple with the problems of society, taking actual responsibility for the health of their local populations." According to him a community-based education is one of the ways that the university can be more responsive to the needs and demands of society. He goes on to say that the locus of care and the locus of action must be where the population lives, works, and is cared for (1993:224). More recently, Yoder, Cohen and Gorenberg (1998:118) have stated that "transforming the nursing curriculum to incorporate practice in community-based sites is no longer a choice" while Oneha, Sloat, Shoultz and Tse (1998:129) report that community-based education has changed the school's philosophy, mission and curriculum. Reed, reporting from the University of Pennsylvania School of Nursing, (1997:139) states that as far as possible students should become an integral part of the community. She sees this as having two advantages - it is helpful in community-

based primary care education and it helps to break down the barriers between the community and the academic centre. Van Hook, from East Tennessee State University, (1997:110) reports that students have identified the following benefits of participating in a community partnership programme:

- confidence in their viability as community-based practitioners was improved;
- it reinforced their career interests and understanding of new options;
- it enhanced problem-solving skills;
- they assumed significant levels of responsibility;
- it generated a broad level of understanding of the roles of health professionals;
- it increased knowledge of managed care;
- they gained from continuity of care experiences, and
- they came to see patients as individuals and as part of families and communities.

However, the need to change is not considered by all the academics as essential. For many the attitude that "its worked up until now, why shouldn't it continue to work?" prevails.
This phenomenon is not unique to any one society or culture, for the literature identifies the barriers to change. Some of these barriers are:

- the fear of loss of control by traditional educators;
- that teachers who were once students in the same system have been socialised to believe in and support that system;
- that individual departments very often do not view themselves as part of the whole. When change for the benefit of the whole will affect individual departments, then it is very likely that the innovation will meet with resistance;
- the time that is needed for the change - to plan and implement can take three to five years. To expect a new curriculum to be in place and to be working smoothly in less time can lead to disappointment and criticism of the changes, and
- that in many institutions promotion and reward is based on research credibilities rather than on teaching abilities (Mennin and Kaufman 1989).

To overcome these barriers Mennin and Kaufman (1989) suggest the following:

- build a broad base of ownership for the change;
- test and modify innovations frequently;
- develop understanding through participation;
- demonstrate ability to compromise;
- describe the new programme as an experiment;
- share rewards, and
- interact with other innovative programmes.

In developing a community-based education for baccalaureate nursing students in Indiana, U.S.A., Eshleman and Davidhizar (1997) have described a five-stage process. The process is described as follows:

- **assessment** - this involves an assessment of the community. The purpose is to learn its beliefs, values, health practices, cultural diversity, socioeconomic groups and specific community needs and problems.
- **conceptualization** - this is the exploring of solutions to meet the needs of the community and academia. It includes the development of a plan to improve the community's health through integrating its needs. During this phase a faculty co-ordinator should be identified who can liaise with the community resource persons.
- **detailing** - this is the designing of experiences to meet specific educational goals.
- **implementation** - this is the actual community experience for the student. The student is expected to be an active participant, involved in problem-solving, communication and intervention. This is seen as essential to facilitate the assimilation of community health concepts. It also generates student enthusiasm and critical thinking.
- **evaluation** - the progress towards academic goals must be a cyclic process between the faculty and the community facility. It must be ongoing.

Yoder, Cohen and Gorenberg (1998:119) describe basic strategies for developing community-based clinical experiences. These are:

- clarifying curriculum goals for community-based care;
- formulating the structural components;
- conducting a community needs assessment;
- investigating community partnerships;
- selecting sites and determining the nature of services, and
- supporting faculty and students operating the services.

With reference to the selection of sites, they go on to say (1998:120) that a key strategy is to attempt to link community needs with the students' educational needs. Inherent in this, is an identification of the resources within the school of nursing and constraints which the school may have.

In a recent study undertaken in a nursing department at a South African university, Cassimjee and Brookes (1998:99) described the concerns and perceptions of 24 second year students in a Baccalaureate Nursing programme. Students felt that it was beneficial to have a programme that moved from health to illness, as this provided them with a sound knowledge of the needs and socio-cultural behaviours of people. However, nine students stated that they were eager to experience nursing in a ward situation. Furthermore, seven students were concerned about their clinical competence in a hospital setting. This was related to the amount of practical experience that they would have gained and that they would have had " too much clinic" and not "enough hospital". Students also had difficulty in understanding the practical relevance of the course. Other concerns raised in relation to community-based education were the violence and difficulty with transport. Some of the students worked in gang-dominated communities that were known for their violence.

2.4.4 THE COMMUNITY AS A LEARNING ENVIRONMENT

The value in using the community as a learning environment cannot be underestimated. Gillies and Elwood (1989:442) identify four key areas in which students can benefit when participating in community project work. These are:

- knowledge - of facts related to the community, health services and clients. This facilitates students' understanding of why people behave as they do in various contexts and situations;
- skills - these include the collection and organization of data, the examination of options and decision making, the development of social skills through interaction with group and other health professionals and skills in communication and report writing;
- attitudes - opportunity to learn to consider attitudes of groups of clients and to work cooperatively, and
- opportunity for students to develop the ability to acquire information using an eclectic approach.

In addition, Yoder, Cohen and Gorenberg (1998:120) state that a benefit of community-based practice is the opportunity for practice and research. However, they go on to identify the conflicts which may arise when functioning on an academic year as opposed to a calendar year. This may result in disturbances of the services offered to the community.

In using the community as a learning environment, Hitalia (not known) suggests having students live with families in the chosen community.

Oneha et al (1998:133-4) have identified student outcomes for undergraduate nursing students in a community-based, inquiry based curriculum. They describe these as follows:

- the ability to analyze information pertaining to the health of individuals, families and groups in collaboration with community members and professionals from other disciplines;
- the ability to use collaboration and partnership rather than the traditional hierarchical structure;
- the opportunity for students to gain knowledge and experience in working with communities, and
- the opportunity for students to work in primary care settings after graduation.

They (1998:135) defined their programme outcomes as follows:

- that at least 50% of the curriculum should be taught in the community;

- that faculty participate as multidisciplinary team members at each site;
- that students would pass the licensing examination, and
- that students would be recruited directly into community-based settings.

Community involvement and participation must be achieved if the community is to be used in the preparation of health care professionals.

2.4.5 CONCLUSION

In developing a community-based education curriculum consideration needs to be given to the anxieties which nurses have expressed when working in communities. These anxieties can be reduced if clinical skills are enhanced in such a way that the student develops confidence in herself rather than becoming dependent on technology. This suggests that students are not exposed to a high-tech hospital environment too early in their studies. Rather their powers of observation and awareness need to fostered at an early stage in their studies. Teamwork needs to be encouraged through small group learning and the qualities of this process transferred into the clinical situation. Students need to be made aware that they are stakeholders in the curriculum and therefore they need to be encouraged to identify, and helped to meet learning needs in relation to the community they serve.

The curriculum should demonstrate active student participation in the community and the community's participation and involvement in the curriculum.

2.5 A COMPARISON OF THE PRINCIPLES OF PROBLEM-BASED LEARNING AND COMMUNITY-BASED EDUCATION.

Little (1998 personal communication) has compared the principles and philosophy of problem-based education with those of community-based education. She says that while PBL is student-centred and CBE is community-centred, both require active participation and ownership of the process. Both focus on process. The process is characterised by problem solving and critical thinking. However, in CBE critical thinking is demanded by community members. In PBL students learn for understanding. Learning is approached conceptually and meaning is constructed from real world applications. In CBE the community constructs its

own meaning from the experience. In PBL students are encouraged to be critically reflective about their practice. This encourages self-directed learning and autonomous action. In CBE, the community is encouraged to critically evaluate their own health practices and this leads to autonomous action.

This comparison suggests that problem-based learning is an appropriate teaching \ learning strategy for preparing practitioners for primary health care practice.

2.6 CHANGES IN NURSING.

The changes that are taking place in health and disease patterns, in technology and in knowledge and understanding, will impact on nursing. This is to be expected, for if it were not the case, nursing would not be responding to the needs of society. Reed and Ground (1997) refer to this as "old nursing" and "new nursing". In comparing the two, they describe how nursing's language and emphases have changed. "Old nursing" was characterised by tasks and functions. The emphasis was on the physical aspects of illness and professional care was distinguished from ordinary care. Success was measured against objective rates of medical success and the emphasis was on results and product (1997:147). "New nursing" on the other hand is characterised by the nursing process, patient-centred care, humanistic and holistic care. The emphasis is on the patient as a person, where health rather than illness is emphasised. Nursing functions are distinct from the functions of the doctor. Success is described in terms of the range of outcomes. The relationship between the patient and the nurse is considered to be part of the nurse's role. The new role of the nurse emphasises patient advocacy and the facilitation of health care. (1997:151).

Changes in the world around us are resulting in changes in the health care systems and the delivery of health care. Previously the health care systems responded to disease and were thus curative by nature. Nursing responded by preparing nurses for hospital practice. As medicine and hospitals became more specialized, so too did nursing by preparing nurse specialists. This specialization of nursing care has added to the cost of health care.

The emphasis has shifted to health and therefore the health care systems are changing. The shift is towards providing care in the community and the home (Mc Closkey and Grace 1997b). Joel (1997:209) states that in America an "explosive" demand for community services has resulted from a change in demographics. She predicts that hospitals will decline in use and that community and home care will grow proportionately. This means that nurses are going to be exposed to a wider population with a greater range of health problems. Reed and Ground (1997:156) state that "for nurses to take on board wider health care issues, their education needs to equip them to do so, and in this sense, the concentration in the nursing syllabi on individualized care is inadequate." Lacey (1997:148) concurs with this. She refers to the revolution in health care and states that nursing education programmes need to prepare nurses to meet the needs of diverse communities. So strongly does she feel about this that she considers that the effectiveness of a nursing education programme is best judged by the ability of its graduates to meet community needs. To this end she writes that the curricula must reflect information relevant to the demographic shifts that concern health disparities among high-risk population groups as well as the social and economic factors that have influenced the quality of life. This has cognisance for a women's health curriculum, in that high-risk groups need to be identified. Women's health needs to be understood in terms of the social and economic factors which influence health and disease patterns.

Reed and Ground (1997:156) go on to warn that "if nurses continue to focus on individualized care, they must accept the implications of it, especially any claims to be part of wider policy making". Gutt (1997:224) speaks of the political empowerment which is necessary to move nurses into a proactive role in policy making for health initiatives and reform. She states that nurses need to become more aware of the sociopolitical realities of their world, to develop a positive group self-esteem and to develop the political skills necessary to bring about change proactively.

If nursing education is to meet these challenges it cannot remain disease focused and hospital based. Shoultz and Hatcher (1997) report that in the transition from a hospital based health system to a community-based system in the United States, nurses express anxiety that they are

not prepared.

Mc Closkey and Grace (1997b:128) state that the change in health care practices is not the only challenge to nursing education. They consider the change in the student body to be another challenge. This statement is very appropriate to the South African scene. During the apartheid era student groups were homogeneous. The white students entering nursing came from backgrounds which had provided them with a reasonable schooling and homes which had all the amenities. These students knew little of and about poverty. The black students entering nursing had come from impoverished home backgrounds and a schooling system that was not comparable to their white counterparts. With the abolition of the Group Areas Act and the opening up of schools, universities and hospitals to all groups the student body has shown a marked change in profile. Nursing is not a popular career choice. This is probably a reflection of the wide choice of careers now available to women the world over. Other factors that may contribute to the lack of interest in nursing as a career are the long and anti-social hours nurses are expected to work, the low salaries, and the poor image of the profession by the public. In South Africa this extends to all groups. Amongst the white students however it appears to be less popular than amongst their black colleagues. This may be a result of the apartheid era and the opportunities afforded these young people by their more advantaged backgrounds. However, as more black children have been exposed to a better primary and secondary education, so have their career opportunities been extended. Nursing was given recognition and status by the black people, but this has also slowly decreased over time. As a result of all these factors the nursing student body today is very different from that of fifteen years ago. The groups today are heterogeneous, come from a variety of school backgrounds and from a variety of lifestyles and life experiences. The heterogeneity of the groups has met with conflict in the lack of understanding of one another's culture and the values and beliefs that are inherent to that culture. Nurse educators have had to manage classes of diverse groups of students; diverse in their existing knowledge, lifestyles, language skills, learning skills, understanding of the meaning of care and motivation to nurse.

Kelly (1997) quotes Johnson who has suggested that one way of meeting the learning needs of culturally diverse groups of nursing students is through the consideration of learning style. Writing from America, Seidl and Sauter (1990) described the non-traditional student. They found that these students were more strongly characterized as discovery learners and that they have experiences and skills that facilitate judgemental ability in professional contexts. In Canada, Laschinger and Boss (1984) found age to be a significant variable in preference for hospital or community nursing. Students under 25 years of age preferred hospital nursing and students 25 and older were equally divided in their preference.

2.7 WOMENS' HEALTH

World-wide health care appears to be under review. In the United Kingdom, the National Health Service is under review, whilst in the United States of America the Clinton administration is debating various options. In the 1993 federal election in Australia, health was a contentious issue (Eckermann 1994:283). South Africa was no exception to this. The health care policy adopted in the post apartheid era in South Africa is that of primary health care. Included in the guiding principles of the National Health Plan (1994) is the right to health. This principle stresses the health care for women and children. The plan includes policies for the sexually transmitted diseases, maternal and child health and for women's health (African National Congress 1994). It states that "women's health shall be understood within a socio-economic context and not within the narrow context of women's reproductive health. Priority will be given to the improvement of women's social and economic status.... The aim will be to empower women through improved knowledge about their bodies and their health" (1994:57).

As in other parts of the world, women's health in South Africa has been considered in terms of reproduction and contraception. This approach has been adopted by the policy makers and has been reinforced in the education of health care professionals. Woods (1995a:61) writes that the health of young women has a profound effect on their health in their middle and older years and yet it is only recently that clinicians are according this fact the attention it deserves.

The cultural aspect of the subservience of women and the domination of medicine by men has only served to entrench this approach to the care of women. However, South Africa has been slow to question and challenge the care given to women. Olesen and Lewin (1985:1) state that it was in the late 1960s and 1970s that feminists in Britain and the United States began to question the level of women's health status and the quality of care they received. They go on to state (1985:3) that "... women's experience in the health care system is not an isolated phenomenon, but one which is influenced by and in turn influences wider societal themes." Fogel and Woods (1995a:xiii) state that these social movements gave women a voice to express their dissatisfaction with the health services. This prompted an alternative service that was marked by new values and that allowed women to assume responsibility for their health.

This section will consider the following aspects - defining women's health, reasons why a women's health curriculum is necessary, a review of the suggested curricula and factors which need to be considered in developing a women's health curriculum in South Africa.

2.7.1 DEFINING WOMEN'S HEALTH

The definitions in the literature concur that women's health embraces the entire life span, that it is more than a biomedical view, that it is influenced by the context of her life and therefore encompasses economic, social, cultural, political and environmental factors (Expert Panel on Women's Health 1997; Breslin 1995; Doyal 1995). The Expert Panel on Women's Health (1997:7) states that women's health care must include health promotion, maintenance and restoration. Breslin (1995:30) states that it is concerned with "... women both as consumers and providers of health care - in multiple settings, while assuming changing roles."

2.7.2 REASONS WHY A WOMEN'S HEALTH CURRICULUM IS NECESSARY

Wallis (1994:14) states that there are six basic reasons for a women's health curriculum. She cites these as follows:

- **Fragmentation.** Women's health needs get lost in the gaps between different medical

specialities. It is expensive, wasteful and generates resentment in women when they are referred between specialists. Olesen and Lewin (1985:3) concur with this. They state that while treating women's health issues as discrete topics does permit some new information to be generated, it does not serve the students well.

- **Differences between men and women.** Differences in women's health supersede the boundaries of the reproductive tract and affect every system. Physiological, hormonal milieu, environmental, societal and economic circumstances shape the course of illness and therapeutic outcome differently in women than in men. Doyal (1995:15) has criticised the biomedical model in women's health care. She states that in using this approach to care the complexity of human phenomena is ignored. She quotes Busfield as saying that this has brought medical practice into scrutiny for its narrow biological orientation and its separation of individuals from their wider social environment. Fogel and Woods (1995b:79) state that despite the growing population of midlife women little attention has been given by researchers and clinicians to their health concerns. They (1995b:83) go on to describe the social changes which may occur for women in their midlife. These may include returning to or changing employment, children leaving home or moving back with parents, a change in the nature of the marital relationship and caring for aging parents. In addition, the increasing longevity has placed women at greater risk for multiple concurrent chronic illnesses. Arthritis, rheumatism, heart conditions, hypertension, depression, senile dementia and urinary problems are common in older women and may occur concurrently (Dimond 1995:106). Dimond (1995) states that to promote growth and optimal aging, women must be given information about their bodies as well as information for a healthy lifestyle. This should include skills in information processing and decision making.
- **Women's dual role.** Women are the major care-givers to husbands, children and parents, but they themselves receive second class care. Graham (1985:26) refers to women as the providers, negotiators and mediators of care. She states that as the providers of health, women are responsible for the domestic conditions which

maintain health and restore health in times of sickness. In their negotiation of health she sees women as health educators. Through the standards which she sets for diet and discipline she teaches through example and in so doing, transmits a culture of health which can be understood. Finally through her domestic health responsibilities she is brought into contact with the health services. Graham sees her as the interface between the family and the state. Doyal (1985) is critical of the health care of women in the National Health Service. She states (1985:258) that "it provides a certain level of medical care for women, but plays only a very small part in the active promotion of their health."

- **Morbidity/mortality**. Women suffer and die as a result of the gender bias in research and medical education. Doyal (1995:17) states that the techniques of biomedical research reflect the white male domination of the profession. This is evidenced in the choice and definition of the problems to be studied, the methodology chosen, and in the interpretation and application of the results. The International Council of Nurses (1995:4) states that most health problems experienced by adolescent girls are still under-investigated. Stacey (1985:291) states that in the U.S.A. the research on women's health issues tend to ignore the importance of class and ethnicity.
- **Role of women physicians**. There is an increase in the number of female medical students and female doctors. Women physicians have always felt responsible for the health of women and children and therefore the time is opportune for the introduction of such a curriculum.
- **Gender bias**. A women's health curriculum is necessary to undo the damage brought on by gender bias in medical education, research and clinical practice. Gender bias is inherent in a male-dominated, male-taught discipline.

Woods (1995b:16) has described how the factors which affect women's health have changed over the past few decades. She lists labour force participation, poverty, longevity, racism and sexism as being some of the more significant factors. She states that what is of more significance is the fact that the majority of women remain employed throughout their lives.

This is irrespective of their marital status or the ages of their children. Furthermore, women tend to live alone more of their adult lives than in the past and the increase in the number of female headed households reflects the difference in marriage and divorce rates. Contemporary women are better educated and have a lower fertility rate. These factors will reflect a change in women's health status and disease profile. Woods (1995b:20) goes on to state that the future prospects for women's health will be determined by health care technologies, women's changing lifestyles, institutionalized sex role expectations, health care delivery and changing biology.

2.7.3 A REVIEW OF SUGGESTED CURRICULA

Cohen, Mitchell, Olesen, Olshansky and Taylor (1994) state that in revising nurse practitioner programmes, they have combined biopsychosocial, multicultural, life span, political and gendercentric concepts into their framework. The paradigm is characterized by a feminist style that incorporates the values of humanism, sensitivity to diverse views, personal concern and collaboration. They go on to state (1994:51) that "a curriculum for clinical practice must incorporate disease management specific to women but must expand far beyond the biomedical framework to include primary prevention, health promotion, healing, caring, and facilitating health across the life span to diverse populations of women." They note too, that health policy, access to and quality of care are integral to the programme. They describe three programmes in women's health care designed for different levels of study. The first two are designed for advanced study and both use primary health care as the core of the programme. The third is a graduate programme and this will be described in more detail. This programme is based in a feminist framework centred in women's life experience and health and illness care needs. Health promotion, health maintenance, and health restoration are studied across the life span. Emphasis is given to the effects of gender on women's lives, health, health care access and health policy. Physiological, developmental, psychosocial and cultural theories are applied throughout and the content centres on the primary health care of women. The continuum is that of health to illness and health care policy is applied within this context.

Wallis (1994) on the other hand describes a curriculum which is structured around a life phase system. The curriculum is divided into five modules. These are:

- Early years - birth to 18.
- Young adult - 19-39.
- Midlife - 40-64.
- Mature years - 65-79.
- Advanced years - 80 and beyond.

Nine content areas are included to a greater or lesser extent in each module. These are:

- Sexuality and reproduction.
- Women and society.
- Health maintenance and wellness.
- Violence and abuse.
- Mental health and substance abuse.
- Transition and changes.
- Patient-physician partnership.
- Normal female physiology.
- Abnormal female physiology.

Sully at City University, London has proposed a framework from which to develop a Women's Health Pathway (Personal communication 1997). Her framework is based on a health - illness continuum. From a base, which she calls Foundation for Practice in Women's Health, she has three main modules. These are fertility control, general gynaecological interventions and malignant disease.

The AAN Expert Panel on Women's Health (1997) calls for greater emphasis on women's health and health care throughout undergraduate programmes. They state that emphasis should be given to gender differences in health, including diagnosis and treatment and to the diversity within populations of women. They recommend that the resources for the preparation of nurses be increased to include primary health care and comprehensive services for women

across the life span. They conclude (1997:14) that " the foci ...include the contexts of women's lives as they affect the health status of individual women and populations of women; the diversity of health care needs as they are related to age, life phase, ethnicity, and race; and the current gender bias of our health care delivery and payment schemes." The International Council of Nurses (1995:3) stated that "it is important to establish a vision of women's health that is comprehensive, woman-centred... and respectful of women's autonomy and individual rights. This concept of women's health should be reflected in nursing education programmes..."

Woods quotes Bricker-Jenkins and Hooyman (1995c:136) who have identified requirements for feminist practice. These are:

- identifying implications of the issues that arise for women;
- recognizing patterns of institutionalized sexism and other oppressive ideologies and behaviours that create problems;
- developing strategies to remove material and ideological barriers to the fullest development of individuals and groups, and
- recognizing that feminist nursing practice is political practice if it enables women to control the conditions of their lives by equalizing power relationships.

Thus, adapting some of these strategies, a possible approach to the development of a women's health curriculum, may be to identify health needs at various stages of the life cycle. In addition and in combination with community-based education, health needs in the community should be identified and addressed in the curriculum. A manageable division of the life cycle would be childhood, the teenage years, the childbearing years, the peri-menopausal period, menopause and post-menopausal years. Applying this approach to, for example, the teenage and childbearing years, one would include contraception or fertility control, the need to monitor for prevalent carcinomas through cervical smears and self breast examination, rubella status and folic acid intake. Other assessment criteria specific to the individual woman's lifestyle would also be identified and health issues addressed in the planning and implementation of health care.

2.7.4 FACTORS TO BE CONSIDERED IN DEVELOPING A WOMAN'S HEALTH CURRICULUM FOR SOUTH AFRICA.

A curriculum for women's health needs to consider the needs of women in their broadest sense, the nature of their health problems and the health care policy of the country. For the purpose of this discussion the National Health policies relevant to women and the status of health of women will be described.

2.7.4.1 NATIONAL HEALTH POLICIES

The National Health Plan for South Africa (African National Congress 1994:57) describes the principal tenets of women's health as the following:

- health promotion in order to enable women to make informed decisions about their health. This will include promoting health advocacy.
- recognition of the right to control the reproductive functions of one's body.
- setting priorities for the improvement of women's economic and social status.
- recognition of women's rights; encouraging women's participation in decision making in health; and freedom from gender oppression.
- the right to choose whether or not to have an early termination of pregnancy according to her own individual beliefs.
- recognition of women's right to live without fear from violence of any kind.

Some of the mechanisms which will be enacted are:

- the development of comprehensive women's health care services, including contraceptive services, which will be geared towards the needs of all women throughout the life span.
- screening programmes for diseases which affect women, e.g. carcinoma of the cervix.
- regulations to ensure the safe and appropriate termination of pregnancy.
- an integrated approach to women's reproductive health care including a package of promotion, prevention, cure and rehabilitation.
- provision of support and counselling services for victims of violence.

- pre- and post-counselling services for those choosing termination of pregnancy.

Some of the principal tenets for maternal and child health care include:

- the reduction in maternal mortality.
- that mothers should be treated with dignity and respect; the promotion of sensitivity to culture and social context.
- the promotion of intersectoral collaboration.
- strengthening of health promotion activities.
- the promotion of family planning.

Some of the mechanisms which will be enacted are:

- the development of a Charter for the rights of women.
- enactment of measures to improve the social, political, legal and economic powers of women.
- the coordination of services.
- general family planning and educational services that are readily available.
- promotion of the survival and protection of mothers through an appropriate health care delivery, health personnel education, training and support ...
- promotion of breast feeding ...
- the availability of all primary health care services at the same venue which are affordable and accessible ...
- early identification of high risk pregnancies, improved antenatal care and provision of emergency obstetric services to reduce maternal mortality.
- free antenatal, delivery and postnatal care and support for women, in the public sector.

2.7.4.2 THE STATUS OF HEALTH OF SOUTH AFRICAN WOMEN.

According to Klugman and Weiner (1992) the health status of South African women is influenced by the following factors:

- **Socioeconomic and gender factors which impact on women's health.** Women live

in a society which is defined and controlled by men. African custom law entrenches women's subordination to men. They are prevented from inheriting or owning houses or property. The lobola system gives a husband right over his wife's body.

- **Political representation and decision making.** Women have had very little say in community affairs and there have been very few women active in political organisations.
- **Employment.** The level of employment is less than that for men, even though many are the sole supporters of their families. When they are employed they are in the least paid, least skilled jobs. This also means the area where there little legal protection. Ngwenya (1994) reports that there is gender discrimination in obtaining a job and if the female is successful, she will earn less than a male.
- **Literacy and education.** The crisis in black education has meant that women's educational status is low. The only professions and jobs where women are noticeably present are the low paid occupations, such as nursing and teaching. In 1994 Ngwenya wrote that "... only three out of ten women have gone to secondary school and only one has a attained a profession" (1994:25).
- **Nutrition.** In the rural areas, poverty and poor farming methods result in a nutrient deficient diet. This is aggravated by cultural traditions where the men eat first and the women get the remains. Oral contraceptives, alcoholism and frequent repeated pregnancies contribute to the malnutrition seen in these women. Iron deficiency anaemia is commonly seen in women of child-bearing age and pica of ash and clay eating aggravate the condition. Obesity is seen in the cities and this is contributing to an increase of diabetes and hypertension.
- **Poverty and the lack of infrastructure.** Diseases associated with poverty, overcrowding and malnutrition are common e.g. tuberculosis.
- **Mental health, violence and disability.** The social characterization of females as mothers pressurizes all women into defining themselves in terms of this role. When they cannot conform to stereotypes, e.g. the inability to have children, they experience stress. Women tend to see themselves in terms of male definitions of the female and

this undermines their confidence and capacity to participate in the broader society. This results in a lowered self-esteem and while this is not mental illness, it does limit her capacity to reach her potential and her sense of wellbeing is undermined. Ngwenya (1994) states that the home is the major source of oppression. The work is hard, boring and there is no credit for it.

- **Employment, overwork and depression.** Many employed women are also responsible for child care. Other stressors which these women face are a lack of status at work, inadequate remuneration, lack of opportunities for training and promotion, sexual harassment and hazardous working conditions. Domestic workers are in an occupation which is repetitive, lacks stimulation, is isolating and allows little time for leisure. All of these factors contribute to depression.
- **Violence.** South Africa is a violent society. Living in such a violent society is stressful. Women are not the actors of violence, but they provide their families with emotional and financial support, while living in fear of loosing a loved one. Violence against women is evident in the form of rape and sexual abuse and harassment.
- **Disability.** It appears that this often results from violence, but the full extent of the problem is not known.
- **Reproductive health and contraception.** Reproductive health is influenced by the sexually transmitted diseases and infertility is experienced by 12% of the African population. Women are reluctant to use contraceptives for a number of reasons. Some of these are the male's negative attitude towards contraception and his power to stop her using a contraceptive; the high infant mortality rate and the politicisation of contraception during the apartheid era. The side effects of contraceptive drugs are also thought to play a role. Many women find the absence of the menses whilst on Depo-Provera disturbing, while for others the increase in appetite and weight gain associated with the contraceptive pill is unacceptable. In the workplace emphasis is put on contraception to prevent disrupting production. Abortion was only legalised in 1997 and the problems created by illegal abortions have taken their toll on women's health. The sexually transmitted diseases and the increasing incidence of HIV positive women

are having a profound effect on women's health. Carcinoma of the cervix is responsible for many deaths in the black women, affecting 1:26 (Epidemiological Comments 1997:6). Teenage pregnancy is common and impacts on the health of the young mother and her child. Health during pregnancy and childbirth is influenced by cultural beliefs and taboos, access to antenatal care, occupational hazards and maternity leave. Maternal mortality rates are high. A WHO poster published in 1997 shows a maternal mortality rate of 200-499/100,000 live births for 1990. The wide range is probably explained by the variation of the services offered and by the woman's ability to access the services.

Dehaeck (199_) has identified the health priorities for women in South Africa. She considers smoking, violence against women, the needs of the aging women, contraception, abortion and carcinoma of the cervix as health issues which need to be addressed by health care providers through health promotion and education.

A factor which the previous two authors do not appear to emphasize in their writings is the issue of culture. South African women come from diverse cultural backgrounds, where the status of the woman is equally diverse. In the black groups the woman is subservient to the male. She is expected to stay at home, care for the children and the home. This may include tending the land and any livestock which forms part of their subsistence. Education for these women is not considered to be necessary. As these women have moved to the cities and have become more urbanized, so their cultural values and beliefs have shifted. This has resulted in conflict for the woman herself as she battles with her traditional upbringing. Amongst other groups, for example, the Moslem women, conflict is experienced as they seek education and the fulfilment of a career. This applies particularly to a woman who wishes to enter the nursing profession, as nursing is not considered to be an appropriate career choice for these women. There is a diversity of opinion amongst the white women. Some are brought up in a Calvanistic home, where her place is seen to be in the home, caring for the males of the family, her children and the home. In this situation, education is not a priority. The more

liberal white women are victims of the Western culture where they are in strong competition with their male counterparts. Education and development in the corporate world are important to these women. Thus, culture is a significant factor in the health status of the South African women. It is evidenced in her nutritional status, mental status and physical status and therefore is a factor which should be considered in every woman's health assessment.

The International Society of Psychosomatic Obstetrics and Gynaecology (1997:12) states that good practice in women's health is based on the recognition of thirteen principles. They divide the principles into four categories, viz. scope, determinants, community participation and methods. The principles are:

- women's health concerns extend over the life cycle and are not limited to reproduction problems.
- women's health problems include, but are not limited to conditions, diseases or disorders which are specific to women, occur more commonly in women, or have differing risk factors in women than in men.
- health must be considered in broad terms and both positively as well as negatively. Dimensions of health include the physical, mental, social, and spiritual.
- women's health is directly affected by a range of socio-cultural, physical and psychological factors.
- women have gender roles and responsibilities which directly affect their level of access to and control of resources necessary to protect their health. These resources are external (economic, political, information/education, a safe environment free of violence and crime) as well as internal (self-esteem, initiative).
- women are diverse in their age, class, race or ethnicity, religion, functional capacity, sexual orientation, and social circumstances. These factors may lead to inequities which adversely affect their health.
- priority should be given to projects in which the issues have been identified as important by the women themselves. Particular attention should be paid to those issues raised by women who are subject to inequities in their society.

- women from the target community should be involved in the planning, implementation, and evaluation of projects involving their health.
- knowledge arising from projects must be accessible to all women but particularly women in the target community. This also means that information must be provided in forms appropriate to different levels of education and literacy.
- to address the complex issues affecting women's health a broad based, interdisciplinary gendered approach is needed, involving and bringing together knowledge and methods of social and health scientists and other disciplines where appropriate.
- intersectoral approaches are needed to address the social factors affecting women's health and life chances. This may involve various governmental departments working together not only with each other, but also with non-governmental and community based groups and the private sector.
- knowledge from projects should also inform and influence government policies and plans, legislation, research, and health care workers.
- where possible there should be resource sharing of skills within regions.

2.7.5 EDUCATION OF THE MIDWIFE

In 1987 (10) a joint report of the International Confederation of Midwives, the World Health Organization and The United Nations Children's Fund called for the education of midwives to prepare her to function effectively at all levels. They went on to state that this could only be achieved if all midwives are exposed to communities and if a considerable part of their education takes place in the community. Kwast (1991:2) states that "..., midwives work mostly in urban hospitals where other colleagues are available and often provide care that could be delegated to different health workers." She goes on to state that midwives are relatively well educated and sophisticated, but are often out of touch with rural women and are seldom willing to work among them.

In 1991 a WHO report (1991b) stated that while nursing curricula are being reorientated to

primary health care, there remain three major challenges. These are:

- **firstly**, to educate in their clinical subject areas (in theory and in practice and in educational technology) a sufficient number of nursing \ midwifery teachers competent in primary health care;
- **secondly**, to develop teaching \ learning resources responsive to changing epidemiology, language and cultural needs; and
- **thirdly**, to develop learning facilities.

In the same year (1991c) WHO called for changes in the conceptual framework of health care in nursing education. The same report stressed the fact that the concept of primary health care embodies community and multi-sectoral involvement. This would require the preparation of nurses who were community-oriented and capable of problem-solving. To meet this need characteristics of the educational programme should reflect a community orientation and be community-based; it should include learning experiences related to identifying and solving individual and community health problems through team work and intersectoral collaboration. As a primary health care approach requires a change in relationship between health professionals and the community, this should also be reflected in the educational programme. To this end, the role of the teacher must become that of a facilitator of learning.

Kwast (1991:4) states that social, political, educational and managerial factors also contribute to maternal mortality and that midwives should be able to act independently in all these spheres.

Writing from an American perspective, Brooten (1997:258) states that those providing perinatal care today are faced with issues involving in vitro fertilization, surrogate parenthood, continued high levels of adolescent pregnancy, a high low birth weight rate, continued problems with access to prenatal care, women receiving late or no prenatal care and early hospital discharge of newly delivered mothers and their infants. This description from a first world country is so very applicable to the state of the maternal services in South Africa.

According to Boult and Cunningham (1991:6) estimates of teenage pregnancy in South Africa vary from 12,4-30 % depending on the definition of adolescence used. They go on to say that black adolescent pregnancy was estimated to be 14 % of all black births in 1989. In 1989 Langeni (1989:17) wrote that in 1985 South Africa had the highest teenage pregnancy rate in the world. With reference to the low birth weight rate, in 1996, 15,6 % of babies admitted to the neonatal intensive care unit were low birth weight (<2,500g) and three percent were very low birth weight (<1500g) (personal communication). While the actual incidence rate may be higher, this does reflect the number of babies who are requiring intensive care (personal communication).

Ten years ago mothers who had delivered their first baby were kept in hospital for seven days post-delivery. If she had a Caesarian Section she was kept for ten days. A mother delivering her second or subsequent baby was kept for five days. Today a mother is discharged anything from six to twenty-four hours post-delivery, sometimes directly from the labour unit. If she had a Caesarian Section she may be kept five days and the mother delivering her first baby may be kept three days depending on the availability of beds. Antenatal patients have been known to sleep overnight in the passage outside the clinic in order to be amongst the twenty who will be "booked" the following day. Other patients are given dates on which to return for their "booking" and often this date is after their expected date of delivery. Early discharge from hospital post-delivery is not new to the South African health care system. This is familiar to the black women who, during the apartheid years, delivered in rural clinics and hospitals. While there are advantages and disadvantages to early discharge, the South African health care system is inadequate in its provision of care for the early discharge of these women. In Johannesburg there is no community midwifery service and the women are told to go their nearest mother and child clinic should they have any problems. These clinics operate from Mondays to Fridays from 08:00 to 16:00 hours and most of them close at 12:00 on Fridays. Furthermore, staff at the clinics seldom accept patients after 13:00, unless it is a real emergency. To the researcher's knowledge the number of undetected problems is not known and she is not aware of any research being undertaken in this area. Follow up phone calls from

the hospital are not possible because many of the patients are from informal settlements or areas that do not have a telephone service. In addition, many of the women give false addresses in order to deliver at the hospital. While these factors impinge on the health service, they also have implications for nursing education. Brooten (1997:261) poses the question: "given the current changes in health care delivery for both perinatal and neonatal patients, what knowledge and skills are now required to care for patients who stay in the hospital for very brief periods?" She calls for a changed workforce who are flexible and focused on thinking and problem solving rather than carrying out a set of tasks.

2.8 CONCLUSION.

In preparing practitioners for women's health, students need to work with women in various urban and rural settings. They need to engage in dialogue with women to identify their health needs and problems. Students need to understand the use and meaning of health statistics and the implications which these have for health promotion. Inherent in all this is the ability to communicate effectively and utilise counselling skills to promote health. Holistic care needs to be provided for women of all ages and from various cultures. In order to meet this need students must develop appropriate cognitive, psychomotor and affective skills.

In this chapter the central themes of the study, viz. problem-based learning, community-based education and women's health have been discussed. An attempt has been made to explain their relationship to one and other. Aspects from each have been identified which have implications for a curriculum in women's health. These may be summarized as follows. The meaning and implications of problem-based learning have been described. The importance of relevant and contextual triggers to promote learning suggests that scenario describing the health problems and needs of South African should be incorporated into the learning packages. Scenario should include women of all ages and in a variety of settings. The principles of community-based education emphasise the learning of conditions which are frequently encountered in the community. Therefore, the health needs and disease profiles of South African women need to be reflected in the problem-based learning packages. The learning packages should reflect the socio-economic, legal and ethical parameters that influence women's health.

CHAPTER THREE

THE CONCEPTUAL FRAMEWORK

> The teacher who walks in the shadow of the temple, among his followers, gives not of his wisdom but rather of his faith and lovingness. If he is indeed wise he does not bid you enter the house of his wisdom, but rather leads you to the threshold of your own mind.
> (Gibran 1997:64)

Education is a phenomenon as old as mankind. Dialogue has always been an important concept in education. Christ used parables, a form of story-telling, to teach and Socrates engaged in dialogue with his students. This facilitated the exchange of ideas from which philosophies developed. Over the centuries interest moved to learning and how it takes place. Thus philosophies of education and learning which influenced curriculum developments have evolved.

For the last twenty-five to thirty years Tyler's behaviouristic model education has influenced nursing education in South Africa. Tyler concentrated on looking at curriculum development through objectives. Bevis and Watson (1989l:3-4) state that Tylerian behaviourism is not bad in and of itself. Its misuse is in trying to apply it uniformly to all nursing curriculum matters and in limiting curriculum exploration to behaviourist theory. They go on to state that behaviourism is a masculine theory. It is materialistic, instrumentalist, reductionistic and empirical and supports procedural knowledge. Furthermore, it lacks the elements necessary in teaching and learning. However, Bevis credits the Tyler model with having led nursing education and nursing practice to professional levels. It forced nursing education to establish criteria to direct the learning process and in this way influenced the practice of the nurse whose education was based on this model (Rentschler and Spegman 1996). Tanner (Paterson and Crawford 1994) states that this paradigm produces students who demonstrate limited

ability to make clinical decisions.

In the 1960's this evaluative activity was questioned as the only means of evaluating an educational programme. It was recognised that context as well as content has real value in judging the curriculum's effectiveness (Whiteley 1992:316-7). Chavasse quotes Corner (1994: 1025) who states that "educational evaluation research has undergone a move which has called for a more holistic approach ... and has moved towards not just examining outcome but also context, process of learning, hidden curricula and all that constitutes education in its widest sense." In 1989 Bevis wrote "...that the objective-driven Tyler model is far too narrow; it inhibits creativity and stifles the learner's potential and no longer provides the framework required for educating a caring scholar-clinician for our complex society" (Rentschler and Spegman 1996:389.) In the same year Bevis and Watson stated that curricula are the interactions and transactions that occur between and among students and teachers with the intent that learning occurs (1989 1:5).

3.1 The Curriculum Revolution.

The nursing education literature has abounded with articles on the curriculum revolution since 1990. The curriculum revolution involved a paradigm shift, - a move from a traditional Tylerian model to a humanistic-educative model. The key concepts which emerge from these articles are critical thinking, caring, life-long learning, empowerment, process skills and informatics (Rentschler and Spegman 1996). Critical thinking, life-long learning, empowerment and process skills have been addressed in chapter two (vide 2.2.2, 2.1.4.2.2 and 2.1.4.2.1, pp 30, 24, 22 respectively). Caring will be addressed in chapter five (vide 5.1.2.9.1 p 179).

3.1.1 The Paradigm Shift

Kuhn described a paradigm as the beliefs, values, techniques, and canons shared by the members of a given community. The community's thoughts, perceptions and values transform when a paradigm shift occurs. This results in a new vision of reality. Four stages are

identifiable in a paradigm shift. These are - the recognition that the old paradigm no longer solves the important issues of the discipline; a greater force outside the community ca'' · for change; intense dialogue occurs in response to the perceived crisis and dete ines the status of the existing paradigm and finally a new paradigm results. At this stage the new paradigm is not readily accepted, but it is tested and retested. The old paradigm is only rejected when the majority of the community have accepted the new paradigm (Rentschler and Spegman 1996:390).

3.1.2 The Revolution

Moccia (1990) writes that it is no strange coincidence that the paradigm shift in education is being referred to as a "revolution". She states that curriculum committees debate ideologies and talk about oppression and freedom. She makes reference to the world's trouble spots of the day and goes on to say that "... the curriculum revolution draws from the ideas of those who testing the idealism of their youth in academic settings find, ... feelings of dispersion and alienation ..." She goes on to say that there is a "drawing together", a search for "something to bring us all together." (Moccia 1990:307). She views the curriculum revolution as a resounding call for transformations in health care, the intentions and substance of nursing education and in the graduands of nursing education programmes (1990:308).

Tanner (1990:297) identifies the major themes of the curriculum revolution as follows:

- social responsibility. This she identifies as the central concern of the revolution. Values which she identifies as being necessary in a socially responsible curriculum are:
    - the enhancement of caring practices through faculty-student and faculty-faculty relationships. These relationships should be characterized by cooperation and community building;
    - "social values that recognize the multi-cultural, multi-racial, and growing diversity of both individual and family lifestyles in our society";
    - "learning experiences that incorporate critique of the current health-care system and analysis of the present and future health needs of the population as the basis

for transforming the health care system; and

- contact with persons at health risk.

- the centrality of caring. Caring is seen as "what allows the nurse, or the teacher, to understand and to act on the concerns and issues of their clientele." It is the centre of nursing.
- an interpretive stance - there is intent to unveil, understand and criticize beliefs and assumptions that guide our practices, but which may be covered over by formal theories, rules or procedures. Interpretation enables us to identify what is good in our practice and to explore new opportunities.
- theoretical pluralism aims to emancipate from the narrow views of what constitutes education. Tanner states that a behavioural model has limited our vision of what counts as quality nursing education. She does however, sound a word of caution here. Theoretical pluralism should not adopt a new but equally enslaving model of education and while standards must be maintained they must be evaluated for their meaningfulness. (1990:298).
- primacy of the teacher-student relationship. She states (1990:298) that apart from theoretical relevance, the teacher-student relationship is central to the revolution in a fundamental way. She states that learning new ways to relate to students constitutes a transformation in world view.

Diekelmann (1990b:300) concurs with Moccia and Tanner. She writes that "..., the curricular revolution is conversations among students, teachers, and clinicians as we seek to transform health care, and the institutions in which we practice nursing, teaching and research." Three of the conversations which she sees as central to the revolution in nursing education are caring, dialogue and practice. Bevis and Murray (1990) refer to this as emancipatory teaching.

Tresolini et al (Tanner 1995) state that we are in a paradigm shift in health care. The paradigm of health which they propose integrates caring, healing, and community. A significant aspect of this paradigm is relationship-centred care. They identify three areas of relationship - practitioner-client, practitioner-community and practitioner-practitioner. The practitioner will

need to be able to apply knowledge, skills and values in each of these relationships. Such a paradigm shift in health care will demand a paradigm shift in the education of nurses. de Tornyay (1990) calls for the empowering of nursing students, but adds a word of caution. She pleads for educators to keep what is good in the curriculum because although much care will take place in the community in the future, hospitals will continue to exist. To produce well-prepared nurses, learning must take place in both settings.

3.1.3 Applying the Curriculum Revolution to the South African Situation

The curriculum revolution in South Africa could be considered to be secondary to the evolution which is taking place in the health care structure. The move towards a primary health care approach and the greater emphasis on women's health have required a shift in the nursing paradigm and a critical assessment of the preparation of nurses and midwives for this shift. At the time of the introduction of primary health care, strategic management teams were established to assess and evaluate the services in the various provinces. Workshops were held for maternal and neonatal services in Gauteng (the province in which this study is set.) Important recommendations for this study from the report (Women's Health Project 1994) are:

- that uniform minimal standards of patient care, appropriate for each level of the service are defined;
- that standards incorporate policies set out in the Perinatal Education Programme and that knowledge of these be a basic requirement of all midwives practising in the province;
- that the possibility of providing services for teenagers and counselling services within each institution be investigated;
- that the possibility of providing home visiting for new mothers be investigated;
- that active community liaison committees be developed; and
- that at least one-third of student clinical experience be gained in academic primary health care centres.

This demands an evaluation of the nursing curricula in terms of their appropriateness for the

preparation of practitioners for such a health structure.

From the literature reviewed, key concepts in the curriculum revolution which are particularly relevant in South African nursing education are critical thinking, caring, empowerment, process skills and dialogue (vide 2.2.2, 5.1.2.9.1, 2.1.4.2.2 and 2.1.4.2.1 pp. 30, 179 , 24 and 22 respectively). These issues will be discussed in more detail, with process skills forming the core concept of the discussion.

3.2 Teaching and learning in nursing education.

Bevis and Murray (1990:326) state that teaching is a political activity, for "embedded in teaching are the hidden messages about what is valued, what learning is about, and who is in power, in control, and on top." Freire (1972) and Bevis and Murray (1990) describe the teaching methods of the traditional curricula as narrative. Freire (1972:45) says that education is suffering from narration sickness: that "the teacher talks about reality as if it were motionless, static, compartmentalized and predictable" and as a result "education becomes an act of depositing, in which the students are the depositories and the teacher the depositor." He refers to this as the "banking" concept of education. At the core of this method of teaching is the lecture method of instruction. Bevis and Murray (1990) state that while the lecture remains as the accepted method of teaching, there will be little movement towards emancipatory teaching. The lecture method has been severely criticised as being oppressive, counter-productive to the development of critical thinking and for creating hierarchies between the teacher and the student (Freire 1972; Bevis and Murray 1990).

Freire (1972:46) states that "knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful enquiry men pursue in the world, with the world, and with each other." He goes on to say that "education must begin with the solution of the teacher-student contradiction, by reconciling the poles of the contradiction so that both are simultaneously teachers and students." In order to emancipate both teachers and learners Friere recommends problem-posing education. Central to problem-posing education is

dialogue. Dialogue cannot occur without active involvement. The shift in the paradigm requires that dialogue is encouraged and that teachers and learners assume different roles in the process. According to Diekelmann (1990b) dialogue is engaged listening, seeking to understand and being open to all possibilities; it is reflecting and probing. She speaks of teachers-as-learners. Their responsibility is to reflect on how their students are learning and to bring different questions into their teaching. In this way the teacher becomes an explorer of meaning with students. The teacher-as-learner is always open to new possibilities, is constantly transforming and being transformed and thus teaching becomes learning (vide 2.1.4.2.3 p 25).

A curriculum that engages in dialogue must also incorporate the concept of care. Bevis (1989g) proposes that emancipatory education requires teachers who are, inter alia, caring. She refers to an emancipatory-educative-caring model. Diekelmann (1990b:301) too refers to caring in a curriculum model based on dialogue. She states that "the sharing of our histories and our struggles to create and recreate communities of care will shift our conversations from the curriculum as a roadmap or pieces of a puzzle, to how we live out our lives as students, teachers, and clinicians in the context of schooling." She states that it is possible to create a pedagogy that is rich in diversity, based in care, reflective of language and dialogue and attuned to the nature of nursing practice (vide 2.1.4.2.1 p 22).

A caring educational environment provides opportunity for the development of critical thinking and empowerment. Sedlak (1997) states that critical thinking is discipline specific with the core ingredient being the foundation knowledge of the discipline. The behaviourist paradigm did not allow for the development or the evaluation of this characteristic in the learner. Beginning practitioners have been found to be very dependent on others for decision-making and problem-solving (Valiga as quoted by Maynard 1996), yet Saarman, Freitas, Rapps and Riegel found that the critical thinking ability of faculty was not significantly higher than that of students when the influence of age was statistically controlled (Videbeck 1997). This may be explained by the structure of the curricula which these persons experienced. A

curriculum that allows for dialogue, that provides opportunity for reflection of practice and for experiential learning will facilitate the development of critical thinking practitioners (Walton 1996). (Vide 2.2.2 p 30).

In contrast to the Tylerian curriculum which has been described as masculine, the curriculum which is based on dialogue and caring is described as feminine in its approach (Noddings 1984; Watson 1989b). Noddings links caring with moral education. She argues that caring involves stepping out of one's personal frame of reference into the other's. She goes on to say that when we care we consider the other's point of view, objective needs and what is expected of us (1984:24). She speaks of an ethic of caring and considers women, by virtue of their biological makeup and socialization, to be better equipped than men to demonstrate this ethic. She considers that the primary aim of eve / educational institution and of every educational effort must be the maintenance and enhancement of caring (1984:172). Noddings describes the roles and functions of the teacher as looking at the subject with the student, engaging the student in dialogue and providing a model in showing herself as one-caring. She considers dialogue, practise and confirmation to be the three great means to nurturing the ethical ideal. Dialogue must be free and open - usually it relates to a fairly well defined aspect, but this is not a requirement - the essence of the dialogue is in the relationship between teacher and learner. Noddings considers the teacher's knowledge to be a critical factor in the relationship. If the teacher is not knowledgeable then she cannot give her full attention to the students who are approaching their learning in different ways.

Watson (1989a) speaks of the tendency in nursing to oppress its young through the socialization process. She states that there is a tendency for oppressed groups to oppress others. Nurses' work, in contrast to that of the doctor, is caring rather than curing. The nature of their work has resulted in them becoming directed, dominated and controlled. Pinch (1996) concurs with this sentiment. She views this as a trap associated with caring. She states that focusing on the more feminine traits, may result not only in feminine characteristics not being rewarded, but contribute to the continuing oppression of women by women. A feminist

pedagogy allows power relationships to be challenged and to be transformed into an egalitarian, shared relationship for learning (Tanner 1990). (Vide 5.1.2.9.1 p 179 for discussion on caring).

Chally (1992) states that empowerment through teaching is a process emerging out of energy from both the student and the teacher as they move toward actualizing a shared vision. It is characterized by caring and the recognition of the humanity of both teacher and student. Empowerment may be viewed either as an outcome or as a process. The process involves a relationship with others and as a result it is shared. It is a developmental concept in which trust is a necessary condition. It is a concept which nurse practitioners can transfer to their clients through helping them to take control over the factors which affect their health (Gibson 1991). (Vide 2.1.4.2.3 p 25 for discussion on the facilitator.)

The student entering a nursing programme in South Africa is very likely to come from an educational and cultural background where she has not been allowed or encouraged to question. Many students come from a family background in which they are taught to respect the wisdom of their elders and a culture where the teacher is in a position of power and status in the society. They are not encouraged to seek knowledge beyond what the teacher has revealed to them. The education system has not been characterized by a climate of trust and caring and has been part of a larger system of oppression. As a result, these students expect to be given the information. The fact that they are paying fees reinforces this expectation. Their lifestyles during their school days were characterised by disruptions caused by riots and by lack of discipline. The riots also resulted in disruptions in the health services because nurses were unable to obtain transport to work or because they themselves were taking part in the strikes and demonstrations.

However, nursing classes are not all homogeneous in their student constitution and it is likely that students from a contrasting background and lifestyle will form part of the same class. Some students come from home and school backgrounds which have been nurturing and

which have encouraged independent thought and learning. These students are familiar with information technology. This is in contrast to their colleagues who may never even have used a telephone or a library or seen a computer. Cultures of learning are in direct opposition. The need to be able to identify own learning needs and for self-directed learning is clearly evident.(Vide 2.1.4.2.2 p 24 for discussion on the students.)

3.2.1 A Curriculum for the "new" paradigm

It is evident from the literature that a curriculum which embraces the qualities of the "new" paradigm may be found in a problem-based learning curriculum. Problem-based learning is emancipatory in that the basis of learning is focussed around the use of problems which allow the learner to identify her own learning needs and empowers her to take responsibility for her own learning. This self-directed learning is guided by the facilitator as he or she monitors the minimum depth of study. However, the student is empowered to explore knowledge to a depth which becomes self-determined. The role of the facilitator is to ensure that this exploration remains relevant and contextual. The lecture is replaced by discussion in groups of varying sizes. Group discussion fosters critical thinking and sharing of information. It also promotes peer teaching and peer evaluation and thus provides a foundation for teamwork in the clinical environment. The teacher's role becomes that of a facilitator of learning. In group discussions her role is not one of power but rather that of an equal as a co-learner (vide 2.1 p 14 for the discussion on problem-based learning).

This study will focus on an evaluation of the existing curriculum and the needs of the learner in nursing and of those depending on the nurse for meeting her needs during childbearing. This will take place within a conceptual framework, which will now be described.

3.3 DEVELOPMENT OF A CONCEPTUAL FRAMEWORK FOR CURRICULUM EVALUATION AND DEVELOPMENT

The conceptual framework for this study uses the concepts of a nursing and nursing education framework and of an educational model to provide the basis for its development. These are

Fawcett's conceptual framework and Stufflebeam's decision making model respectively. Donabedian's quality assurance model and Parlett and Hamilton's Illuminative evaluation model are used to guide the data collection processes necessary to further explain the concepts of the former two models.

3.3.1 FAWCETT'S CONCEPTUAL FRAMEWORK

Fawcett defines a conceptual model as referring to global ideas about the individuals, groups, situations, and events of interest to a science (1980:10). The concepts are then linked to form propositions stating their interrelationships. Four metaparadigm concepts specify the phenomena of a nursing conceptual model. These are person, environment, health and nursing. The conceptual model embraces the paradigm of the discipline. She goes on to state that "the function served by a model determines the type of speculations required to further explain events. In nursing, conceptual frameworks act as general guides for practice, research, curricula, and administrative systems." Further development of the model is influenced by the (in this case) particular educational programme.

In applying this framework to an educational programme consideration must be given to the approach to the development of nursing knowledge. Aspects which may be considered here include the relationships of person, environment, health and nursing and areas of concern in nursing (Watson and Herbener 1990:317). Questions which Fawcett states need to be considered here are:

- the approach to the development of nursing knowledge;
- the four essential concepts - person, health, environment and nursing - how they are defined and their relationship to one another
- problems with which the model is concerned and the source of these problems (1980:12).

These questions will be considered in the description of the framework (vide 3.4 p 87).

Current models and theories of nursing have not been used utilised in this study, as they are

inappropriate for a country which is a mixture of first and third worlds and which has a complexity of cultures and language groups.

3.3.2 STUFFLEBEAM'S DECISION MAKING MODEL

In his curriculum model Stufflebeam (1971:23), an educationist, uses the concepts context, input, process and product (CIPP) and states that "... the CIPP Evaluation Model provides both proactive support for decision making and retroactive support for accountability."

The CIPP Model defines the process of delineating, obtaining, and providing useful information for judging decision alternatives "(Stufflebeam 1971:19). Crucial to this definition are three important points, viz. that evaluation is a systematic, continuing process; that the evaluation process includes delineating the questions to be answered, the obtaining of relevant information and the providing of information to decision makers for their use to make decisions, and that evaluation serves decision making (Stufflebeam 1971:19). It is proposed that each concept is influenced by a number of factors. An analysis of these factors facilitates curriculum development and evaluation.

This may be explained as follows:

3.3.2.1 CONTEXT - this involves an examination of the environment in which the curriculum exists. Some of the questions which may be asked here are:

what is the purpose of the programme?

what is it trying to achieve?

and is there need for such a programme? (Clark, Goodwin, Mariani, Marshall and Moore 1983:43).

Some of the steps which may be considered in answering these questions are:

- an examination of the society's and community's needs for professional nursing services;
- an examination of current trends in nursing practice and nursing education nationwide and in the specific geographic location;
- an examination of the congruency between philosophy, beliefs and purposes of the university and nursing;

- the decision to develop a curriculum based on a nursing model versus a medical model;
- the selection of a nursing model to provide a framework for the curriculum (Clark et al 1983:55).

3.3.2.2 INPUT - this is an analysis of the actual and potential resources, facilities and strategies available. Some of the steps which may be considered here are:

- an evaluation of the impact of the curriculum change on the system in terms of time factors, space factors, cost and equipment;
- identification of faculty responsibilities in relation to change, areas of expertise and commitment in implementing change;
- decide if physical, financial and human resources in the system are capable of sustaining the change (Clark et al 1983:55).

3.3.2.3 PROCESS - this directs implementing by describing the actual functioning of the system and identifying areas of weakness (Clark et al 1983:55).

3.3.2.4 PRODUCT - this refers to the outcome of the objectives of the programme. One of the questions which may be asked here is whether the programme has benefitted those intended, viz. the students and the community? (Clark et al 1983:55). Some of the steps which may be used here are age at graduation, sex, students' professional performance as evaluated by employer one year after graduation and students' evaluation before, during and after entering the programme to determine the effectiveness of the programme in improving knowledge and skills (Clark et al 1983:56).

Each concept is linked to the next so that a cycle develops (see figure 3.1 p 82). Whiteley (1992: 318) states that the disadvantage with this model is that it assumes that process is open to scrutiny and this may not always be the case. In adapting this model to nursing Sconce and Howard (1994:282) see the concepts of context and input as being integral to the professionalism of those involved.

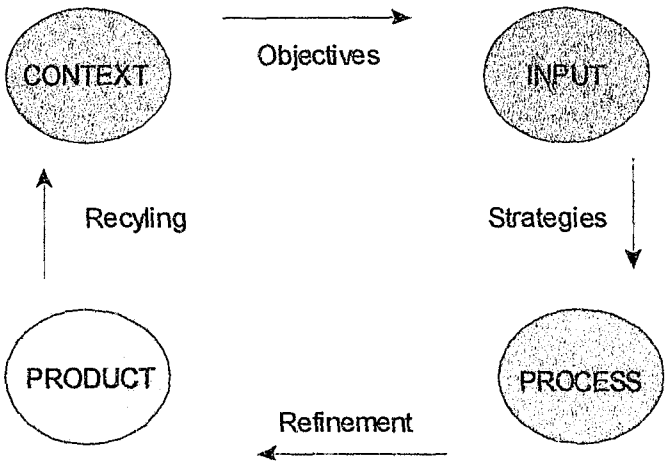


Figure 3.1 Relationship of the four concepts of Stufflebeam's decision making model

The two models described above each have four concepts. Each concept from the nursing framework can be aligned with a corresponding concept in the educational model. This can be illustrated as follows:

Fawcett's Conceptual Framework	Stufflebeam's Model
Environment	Context
Person	Input
Health\Illness	Process
Nursing	Product

In order to describe these concepts the views of Donabedian and Parlett and Hamilton will be considered.

3.3.3 DONABEDIAN'S QUALITY ASSURANCE MODEL

This model utilises three concepts - structure, process and outcome.

Donabedian's model arose out of a review of key studies which looked at the assessment of the quality of care. He states that "... the quality of care is a remarkably difficult notion to define" and goes on to say that patient care cannot be considered as a unitary concept (1979:187). He discusses various approaches to assessment which have been used over time. Outcomes of care have been used as an indicator of the quality of care. However, there are a number of considerations which limit their use as measures of the quality of care. Firstly, outcome may not be the appropriate measure, and secondly, it may be difficult to measure, e.g. patient satisfaction. He concludes that it does not mean "... that outcomes are inappropriate indicators of quality but to emphasize that they must be used with discrimination. Outcomes, by and large, remain the ultimate validators of the effectiveness and quality of medical care" (1979:188).

Another approach to assessing the quality of care is to examine the process of care itself. In this approach attention is given to specifying the relevant dimensions, values and standards to be used in the assessment. While the estimates of quality which one derives from this approach are less stable and less final than those derived from outcome measurement, they may be more relevant to the question at hand.

The third approach is to examine the settings in which the process takes place. This he labels the assessment of structure. It is concerned with such things as the adequacy of facilities and equipment and the qualifications of the staff. This approach has the advantage of dealing with fairly concrete and accessible information, but has the major limitation that the relationship between structure and process or structure and outcome, is often not well established (1979:189). Furthermore, while structure and process are no doubt related, the relationship is complex and ambiguous (1979:206).

Methods which may be used in collecting information in these approaches include clinical records, direct observation and the indirect study of behaviours and opinions. He notes that studies of quality are usually concerned with one of three objects. These are:

- the actual care provided by a specified category of providers of care;
- the actual care received by a specified group;
- the capacity of a specified group of providers to provide care (1979:194).

Donabedian concludes that the approaches may be said to be of doubtful value and often lacking in rigor and precision, "but how precise do estimates of quality have to be?" (1979:209).

In applying Donabedian's model of structures, process and outcome to curriculum evaluation, structures refer to what is needed to provide and support the curriculum; processes are the means by which the curriculum is delivered and received and outcomes are the results for the participants and the overall impact of the curriculum in question (Whiteley 1992:320). Some of the questions which may be asked in relation to these concepts are as follows:

Structure questions - how is the curriculum planned and developed?
- what teaching methods are involved?
- how is assessment carried out?
- how is the student given support?

Process questions	- how effective were the teaching methods?
for participants	- how useful was the content?
	- was there enough support?
	- were the practice placements effective?
Outcome questions	- did the course meet your needs?
for participants	- was there any link between theory and reality?
	- what are the benefits to you? (Whiteley 1992:321-322).

3.3.4 ILLUMINATIVE EVALUATION

Parlett and Hamilton have been described as "new-wave" evaluators who have emphasised a more naturalistic approach to enquiry. Their **illuminative evaluation** is based on description and interpretation. It is a combined approach using observation, interviews with participants and analysis of background information to illuminate problems, issues and significant curriculum features (Whiteley 1992:319). Through these means the evaluator seeks to recognise themes from which to develop further lines of enquiry. A problem which may arise from this method is data overload (Chavasse 1994:1029).

Their model developed out of their observation that programme evaluation tended to be characterised by conventional approaches which were based on experimental and psychometric traditions. The aim of these studies was to achieve objectivity, but instead they are artificial and restricted in scope. They state that "... such evaluations are inadequate for elucidating the complex problem areas they confront and as a result provide little effective input to the decision-making process" (1977:10). They recognise that as a new field of study programme evaluation has been confronted by numerous problems and that in educational research two paradigms are evident. These are the more dominant "classical" or "agricultural-botany" paradigm and the empirical studies (1977:11). In the former students are given pre-tests and then submitted to different experiences. These studies are designed to give objective, numerical data that will permit statistical analysis. However, these studies do not take

cognisance of the numerous parameters which characterize educational situations. Illuminative evaluation takes account of the wider contexts in which programmes function and in so doing its primary concern is with description and interpretation rather than measurement and prediction (1977:13). They describe the aims of illuminative evaluation as;

- the study of the innovative programme - how it operates and how it is influenced by the various situations in which it is applied;
- how students' intellectual tasks and academic experiences are most affected;
- to discover and document what it is like to be participating in the scheme, whether as teacher or pupil;
- to discern and discuss the programme's most significant and recurring features and critical processes (1977:13).

Parlett and Hamilton state that central to an understanding of illuminative evaluation are the instructional system and the learning milieu (1977:14). The instructional system is the description of the course in the prospectus. When it is evaluated it is done so using a methodology that fits this description. What is not acknowledged is that the implementation of the course is very different from what is described in the prospectus. This is because it is subject to teachers and learners interpretation of the course in their settings. When this is recognised a new concept is required - the learning milieu. They lescribe this as "... the social-psychological and material environment in which students and teachers work together. The learning milieu represents a network or nexus of cultural, social, institutional, and psychological variables" (1977:14). These variables cannot be ignored because they interact in complex ways and penetrate the environments in which teaching and learning occur. It is essential that this diversity and complexity is acknowledged before studying educational programmes.

3.3.4.1 Illuminative evaluation - what it is.

It is not a standard methodological package, but a general research strategy, which aims to be both adaptable and eclectic. The problem defines the methods used, not vice versa and there

is no attempt to manipulate, control, or eliminate situational variables. These are taken as givens in the complex scene encountered. The emphasis is on observation in the classroom and on interviewing participating teachers and learners. Three stages can be identified:

- investigators observe;
- enquire further;
- seek to explain.

The three stages do overlap and are functionally interrelated. During the three stages data are collected by making use of observation, interviews, questionnaires and documentary and background sources (Parlett and Hamilton 1977).

3.3.4.2 Possible problems.

Parlett and Hamilton (1977:21) raise possible questions in the use of illuminative evaluation. These are:

- Concern over the "subjective" nature of the approach. They point out that any research study requires skilled human judgements and is thus vulnerable.
- Extensive use of open-ended techniques does raise the issue of partiality on the part of the investigator. Precautionary tactics are possible and should include the use of different techniques to facilitate cross-checking; the use of outside researchers to check coding; commission team members to develop their own interpretations.
- Research workers need not only technical and intellectual abilities, but also interpersonal skills.

Parlett and Hamilton (1977) conclude that evaluation studies contribute to decision-making and that illuminative evaluation contributes to information-gathering rather than to the decision-making component of evaluation.

3.4 THE CONCEPTUAL FRAMEWORK

Burns and Grove (1993:171) state that "a framework is the abstract, logical structure of meaning that guides the development of the study and enables the researcher to link the findings to nursing's body of knowledge." The aim of the study is to develop a curriculum

for students in an undergraduate nursing curriculum for women's health. It therefore, has a nursing and an educational component to it and thus considers frameworks and models from both nursing and education.

This framework incorporates one conceptual framework and three conceptual models. Fawcett's conceptual framework and Stufflebeam's Decision Making Model form the basis for its development . Donabedian's Quality Assurance Model and Parlett and Hamilton's Illuminative Evaluation Model provided guidelines to the types of questions which should be asked about the concepts identified in Fawcett's framework and Stufflebeam's CIPP model. Hence, the latter two models guided the research methodology.

3.4.1 IDENTIFICATION AND LINKING OF CONCEPTS

This framework links the concepts of a nursing framework, viz. person, health, environment and nursing, with those of an educational model, viz. context, input, process and product. (These concepts have been described above. Vide 3.3.1 and 3.3.2 pp 79 and 80 respectively). It has also been shown that each concept of the nursing framework can be aligned with the concepts of the educational model (vide 3.3.2 p 83). In linking the four concepts of each, viz. environment <-> context, person <-> input, health <-> process and nursing <-> product, four new concepts emerged. The four new concepts are environment, registered midwife, curriculum and outcome. These concepts are defined below.

3.4.1.1 DEFINITION OF CONCEPTS

- **environment** - this refers to the broader environment and includes the hospital. It refers only to the women in the environment. The environment is essentially an urban environment. The city in which the study is set is the largest in South Africa, and is situated in the smallest of the provinces. This province is also the most populated. The environment is characterised by overcrowding, poverty, crime and violence.
- **registered midwife** - the registered midwife is the teacher in both the academic and practical situations. She has registration with the South African Nursing Council as a midwife following either a one-year post-basic diploma or an integrated diploma or

degree programme. It includes the resources available for teaching.

- **curriculum** - this is the process through which the student in the basic undergraduate nursing programme learns about health and illness. Curriculum incorporates the learning environment. The learning environment refers to both the theoretical and clinical learning environments and includes the resources available within each of these.
- **outcome** - is the graduand or product of the process or curriculum through which nursing and midwifery is learned. She has obtained the Baccalaureate degree in Nursing of the University of the Witwatersrand. In this framework and study "she" refers to both male and female students and / or registered midwives. This gender has been chosen because the majority of the students are females , as are the majority of the registered midwives in the clinical facilities.

In order to describe these concepts the Donabedian's and Parlett and Hamilton's models have been applied.

3.4.1.2 IDENTIFICATION OF RESEARCH METHODOLOGY

Quantitative and qualitative methodologies and their related data collection processes have been identified. These methodologies have been selected based on the objectives of the study (vide 1.6 p 9), the concepts which have been identified and which need to be described. Donabedian's and Parlett and Hamilton's models have guided the questions which need to be asked in relation to these concepts. Thus the data collection process is described as follows:

- **environment** - the hospital environment will be studied through the use of a survey of post-natal women, using a structured interview schedule.
  - the community will be studied by using focus groups to obtain the opinions of women in the community.
- **registered midwife** - the profile and opinions of registered midwives will be obtained through the use of a structured questionnaire
- **curriculum** - the value of the current curriculum will be evaluated by obtaining the opinions of students currently in the process. This will be achieved through the use of a structured questionnaire which is adapted to the student's year of study.

- **outcome** - the value and credibility of the curriculum will be assessed through the use of focus groups held with clinical midwifery supervisors and graduands who have continued in the practice of midwifery upon completion of their studies.

The paradigm shift which is occurring in the health care structure and in the education of nurses and midwives is examined against the concepts of the conceptual framework, viz. environment, registered midwife, curriculum and outcome. Based on the findings of the data collection processes, implications for education in women's health will be identified and a curriculum for undergraduate nursing students will be suggested. The conceptual framework is diagrammatically described in Figure 3.2 (vide p 92).

3.4.1.3 A CRITIQUE OF THE FRAMEWORK

Burns and Grove (1993:199) suggest a theoretical substruction to critique a framework. They pose questions which may be used to guide the analysis. These questions are as follows:

- Is the framework based on a substantive theory or a tentative theory? The framework is based on a substantive framework and three models.
- Was a conceptual model included in the framework? The conceptual framework and the three models are included in the framework.
- Is the definition of constructs consistent with the theorist's definition? The conceptual framework for this study aims to study the environment, the registered midwife, the curriculum and the outcome in the context of developing nursing knowledge such that it is relevant and appropriate for the society in which it is to be implemented. These definitions are consistent with those posed by Fawcett and Stufflebeam.
- Do the concepts reflect the constructs identified in the framework? The concepts, environment, registered midwife, curriculum and outcome reflect the constructs identified in the framework and models, e.g. registered midwife reflects Fawcett's construct of person and Stufflebeam's construct of input.
- Do the variables reflect the concepts identified in the framework? An example of this is environment which is defined broadly to include the hospital, but is confined to

women in the environment. The variables women, hospital and community are reflective of the concept environm nt.

- Are the operational definitions reflective of the conceptual definitions? This is illustrated in the concept curriculum which reflects Fawcett's "health/illness" concept and Stufflebeam's "process" concept.
- Are the propositions logical and defensible? The propositions are logical in that women require health care and are dependant on health care givers who in turn require education to provide this care. The education of the care giver may reflect on the quality of care the care giver is able to afford. The propositions are defensible in that they can be studied and subjected to analysis.
- Is evidence from the literature used to validate the propositions? Evidence from the literature has been used to validate the propositions.
- Are the hypotheses, questions, or objectives logically linked to the propositions? The research questions and objectives are linked to the propositions.
- Can diagrams of the propositions be linked to the conceptual map? The propositions can be linked to the conceptual map.
- Is the conceptual map adequate to explain the phenomenon of concern? The conceptual map is adequate to explain the phenomenon of concern, viz. a curriculum for women's health.
- Is the design appropriate to test the propositions? The research design is based on a needs approach and draws on data collection methods from both quantitative and qualitative methodologies in an attempt to validate the findings.

3.5 CONCLUSION.

In this chapter the paradigm shift which is occurring globally in nursing education is described. This demands an evaluation of current curricula. In order to evaluate and develop a curriculum for undergraduate nursing students in women's health a conceptual framework is proposed. This framework was developed using an eclectic approach, drawing on the writings of Fawcett, Stufflebeam, Donabedian and Parlett and Hamilton.

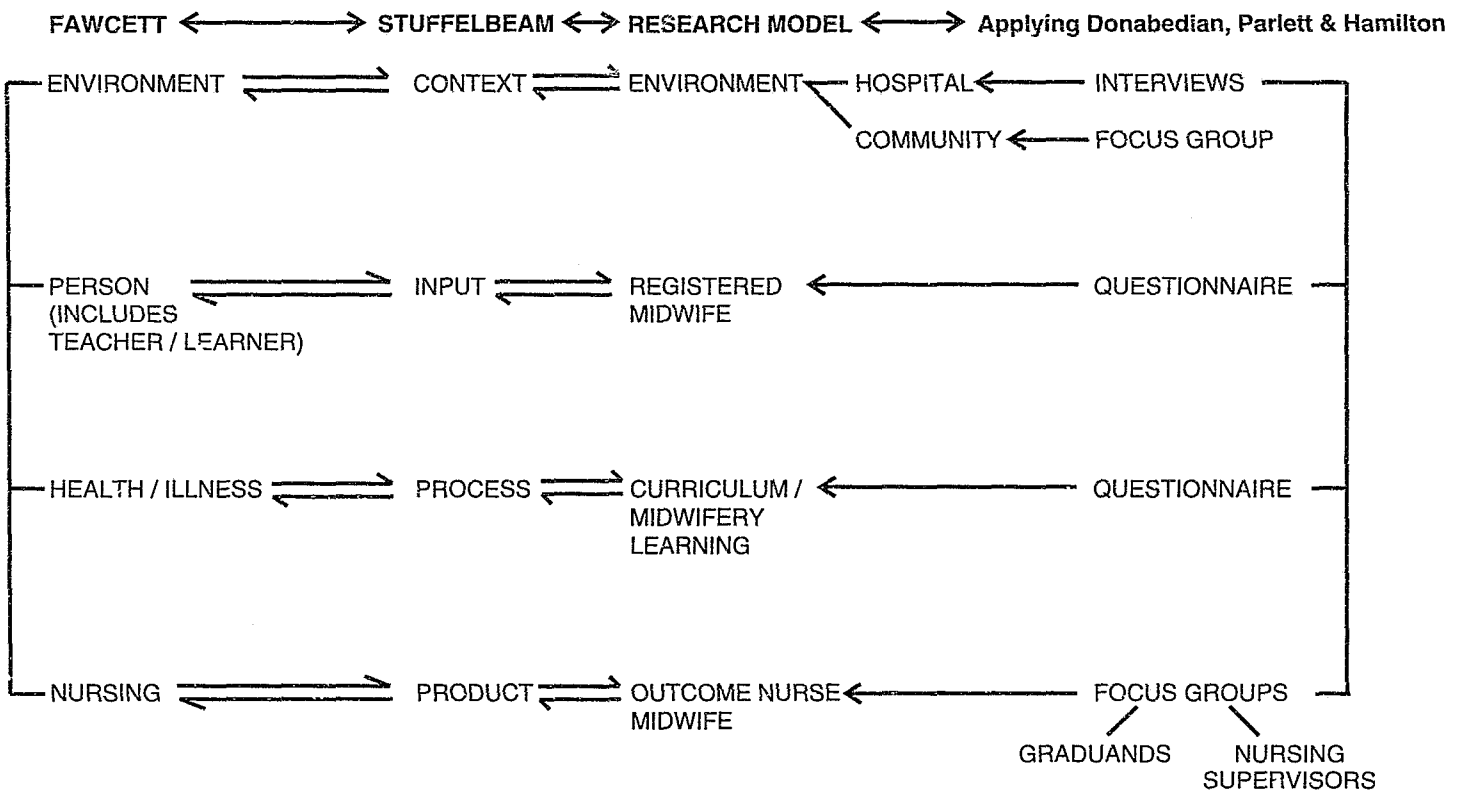


Fig 3.2 Diagrammatic representation of the conceptual framework for the development of a curriculum in women's health

CHAPTER FOUR

METHODOLOGY

You would know in words that which you have
always known in thought.
(Gibran 1997:62)

This chapter will be divided into two parts. In Part A the methodology relating to the nursing \ educational concepts of the conceptual framework will be described and in Part B the development of the problem-based curriculum will be described.

4.1 PART A - NEEDS ASSESSMENT

The research design which was chosen to study the nursing \ educational concepts of the conceptual framework was that of a needs assessment.

4.1.1 Needs assessment as research methodology.

A needs assessment is one of three categories described in evaluation research (Bond 1996). Bond (1996:190) states that a needs assessment "... is not evaluation of an existing project at all but a means of seeking an assessment of needs, problems or conditions which should be taken into account and addressed in future planning." It is used when there is a need for information and when there is a need to clarify goals and assess the extent to which they are shared. A needs assessment enables one to determine whether clients perceive problems and decide whether there should be new forms of action. Krueger (1994:30) states that "..., needs assessment surveys tend to identify concerns that already have achieved some visibility within the community as opposed to the less visible concerns that lie below the surface." To overcome this problem he suggests that focus groups follow the quantitative procedures. He states that focus groups can provide insight into the meaning and interpretation of the survey results and can " ...suggest action strategies for problems addressed in the questionnaire." He

writes that needs assessment surveys often only give part of the desired information and may omit sor of the more crucial information.

In contrast to Bond's (1996) statement, Polit and Hungler (1991) distinguish between evaluation research and needs assessments. They do state that both evaluation research and a needs assessment attempt to provide a decision maker with information for action. They (1991:203) describe a needs assessment as "... a study in which a researcher collects data for estimating the needs of a group, community, or organization. A needs assessment provides informational input in a planning process." They go on to say that while an evaluation seeks to determine whether a programme is achieving its objectives, a needs assessment seeks "... to determine if the objectives of a programme are meeting the needs of the individuals who are supposed to benefit from it." Polit and Hungler (1991:203) identify three approaches to a needs assessment. These are:

- the key informant approach,
- the survey approach, and
- an indicators approach.

In the key informant approach, data are collected from the key individuals. Data is usually collected through the use of questionnaires and interviews. In the survey approach, data is collected from the target group whose needs are being assessed. This means that data is collected from any member of the group. There is no need for that individual to be in position of authority or to be knowledgeable. The indicators approach makes use of inferences drawn from statistics. Thus, the needs of this study were best met by the survey approach, as the researcher wished to determine whether the goals of the current curriculum met the needs of women. Furthermore, there was no need for women to be in position of authority or knowledgeable in order for them to give their opinions.

Polit and Hungler (1991:203) state that the final stage of the needs assessment is to make recommendations. This requires that the researcher identifies priorities which are revealed in the findings. They state that "... , the suggestions are rarely entirely objective."

4.1.2 Needs assessment in education.

Several authors (Mertens 1998; Borg and Gall 1989; Mc Killip 1987 and Stufflebeam, McCormick, Brinkerhoff and Nelson 1985) have described the use of needs assessments in education. Mc Killip (1987:20) identifies three models of needs assessments - the discrepancy model, the marketing model and the decision making model. He states that the discrepancy model is the most widely used especially in education. Mertens (1998:222) credits Stufflebeam, an educationist, as being instrumental in redefining evaluation. She says that he moved the emphasis from the achievement of objectives to include the idea that it is a process of providing information for decision making. She says that the CIPP model attempts to incorporate many aspects of the programme that were not previously considered. She goes on to say that the context and input phases represent a needs assessment function that evaluation sometimes play to determine what is needed in a programme.

Stufflebeam et al (1985) state that needs assessments are used to address most areas of educational programming and student growth. They identify four reasons for implementing needs assessments. These are:

- to assist in planning;
- to promote effective public relations;
- to identify and diagnose problems, and
- to assist in the evaluation of the merit and worth of a programme.

They go on to say that a needs assessment is a diverse process and an endeavour which occurs at almost every level and area of education. It usually addresses a future-oriented question. They state that a problem with a needs assessment is defining what is meant by a need. They define a need as something which is necessary or useful and not simply a preference. Thus they (1985:16) define a needs assessment "... in general as the process of determining the things that are necessary or useful for the fulfillment of a defensible purpose."

They state that a needs assessment serves two primary functions:

firstly, it assists in determining what needs exist and how these needs should be addressed, and

secondly, it can provide criteria against which a programme's merits can be evaluated, i.e. the

degree to which intended or important human needs are addressed effectively and efficiently.

The research design may be described as that of a needs assessment which subsumes quantitative and qualitative approaches.

4.1.3 Triangulation.

A feature of this study is triangulation. Burns and Grove (1993:277) state that it was first used by Campbell and Fiske in 1959 and that it is the combined use of two or more theories, methods, data sources, investigators, or analysis methods in the study of the same phenomenon. At least four types of triangulation have been described, viz. data triangulation, investigator triangulation, theoretical triangulation and methodological triangulation (Burns and Grove 1993; Polit and Hungler 1991). This study makes use of data triangulation and methodological triangulation.

Cowman (1993:790) states that "data triangulation involves collecting data from multiple sources for analysis in the same study with each source focused upon the phenomenon of interest." This study collects data from women in hospital and community based settings, from nursing students, graduands and nursing supervisors. In so doing, use is made of structured interview schedules, structured questionnaires and focus groups.

Two types of methodological triangulation have been identified. Mitchell describes "within method and across method". Within method involves the use of one method and the use of different strategies within that method (Cowman 1993). This is said to be the simpler of the two (Burns and Grove 1993:278). Across method involves the use of dissimilar, but complementary methods (Cowman 1993). Cowman (1993:790) states that "the combination of dissimilar methods provides opportunities for counter-balancing the weakness of one method with the strengths of another. It allows for the combination of both qualitative and quantitative methods of data collection within the same study." By so doing, it aims to secure an in-depth understanding of the phenomenon in question (Denzin and Lincoln 1994:2) This study adopts such an approach.

Mitchell identified four principles which should be applied in methodological triangulation.

These are that:

- the research question must be clearly focused;
- the strengths and weaknesses of each chosen method need to complement each other;
- the methods need to be selected according to their relevance to the phenomenon being studied, and
- the methodological approach needs to be monitored throughout the study to make sure that the first three principles are followed (Burns and Grove 1993:279)

Burns and Grove (1993:280) write that the quantitative \ qualitative approach to data collection has met with mixed reactions in the nursing research community. Some see the combination of the two as "inevitable and essential", while others view the combination as "incompatible." Polit and Hungler (1991:527) state that reality is complex and the integrated approach allows for insight, strengthens validity and allows for greater depth of enquiry into discrepancies. Denzin and Lincoln (1994:2) view triangulation as an alternative to validation.

4.1.4 Needs assessment and the conceptual framework

Thus, a needs assessment was used to examine the concept of environment in order to determine the needs of the women, both in the community and hospital settings. It was used to assess the needs of the student from the educational (curriculum) viewpoint and from the clinical (registered midwife) viewpoint. The outcome of the current curriculum and its deficits were evaluated through the concept outcome which seeked to determine needs of the graduand on entering clinical practice as a professional midwife.

4.2 DATA COLLECTION PROCEDURES

The data collection procedures which were used were identified in the development of the conceptual framework (vide 3.3. p 78). The procedures will be described under the concepts which are a combination of the nursing framework and the educational model.

4.2.1 PART A

4.2.1.1 SECTION A - ENVIRONMENT

4.2.1.1.1 The setting

The interim government of national unity has stressed the necessity to address needs at a local / regional level. For this reason it was decided to confine the research to the Gauteng region and more specifically, the Johannesburg area - given that a nursing college and university provide for nursing education in the Pretoria area. The setting for this section comprised of two research areas - the hospital setting and the community setting. The population to be studied in both of these settings was women (vide 3.4.1.1 p 88). The main referral hospital within the Johannesburg area serves a heterogeneous population. The following aspects were examined:

- the obstetrical problems most frequently encountered by childbearing women. This was done by reviewing the statistics of the maternity section of the main referral hospital over the period of one year. The nature and frequency with which these conditions are encountered are significant when developing a curriculum that considers the needs of the community.
- women attending the hospital's maternity unit were interviewed to determine women's perceived needs during pregnancy, labour and the puerperium.

The emphasis on the childbearing woman relates to the legislation governing the registration of students as midwives on completion of their degree (vide 7.2 p 275). Care of the pregnant woman will still comprise a major portion of the curriculum.

4.2.1.1.2 The sample

4.2.1.1.2.1 Hospital setting

Within the hospital setting a sample of 250 women attending the Johannesburg Hospital's maternity section were interviewed. The sample number was determined in consultation with a statistician. The purpose of this interview was to determine the needs of the women and to gain some information from them regarding the care they expected to be given and how they perceived the actual care that they received. Initially it was planned to draw half of these

patients from the lower socio-economic groups and half from the upper socio-economic groups, utilising the hospital's classification system which is based on income and assets. However, before this section of the research was commenced free maternity services were introduced in June 1995. The researcher consulted with the relevant administrators and was told that patients would still be classified on the old system for statistical purposes. Therefore the interview schedule made provision for this. However, when interviewing began it was found to be of no value as the greater majority of the patients were classified as "free" patients.

4.2.1.1.2.1.1 Research design

A survey method was used. This approach was chosen because it allows the characteristics of the group using the facility to be examined by asking individuals from that group a series of questions. Survey research is non-experimental research, that seeks to obtain information regarding a situation. Polit and Hungler (1991:193) state that "the greatest advantage of survey research is its flexibility and broadness of scope." A limitation of this method is that the information obtained may be relatively superficial. For this reason it is better used for extensive rather than intensive research. It does not allow for cause and effect relationships to be inferred because variables are not manipulated. The demand that it places on personnel will have some impact.

4.2.1.1.2.1.2 Population

The population consisted of all women who delivered at the hospital, whether they had attended the ante-natal clinic or not.

4.2.1.1.2.1.3 Sample

The sample was drawn using a systematic sampling technique. The maternity register in labour ward was utilised for this purpose and every third name was drawn, starting each day from the last name entered on completion of the sampling for the previous day. The sample was collected during the months March to July using a different week of each month. At the

beginning of each week the sampling began from names entered after midnight of the day beginning the study week. Sampling was done by the researcher. Interviews were conducted over a five month period, using a different week of each month.

4.2.1.1.2.1.4 Pilot Study

A pilot study was conducted on ten women who had had their babies at the hospital's maternity unit. From this it became clear that the method of data collection would require an interview schedule as only two of these women were literate. It was also evident that the questionnaire would need to be translated and that the help of a research assistant would be required. Some of the questions lacked clarity and the necessary changes were made. Questions which needed amendment were question 1 (needed categories for age less than 15 years); question 4 needed categories for clinic, not applicable and other; question 7.2 needed rewording and question 8 was changed completely so that it became more structured. The reason for this was it was realised during the pilot study that women appeared to have little or no idea of what to expect or what they wanted from the service. Question 17 had a extra category added for "hardly at all". The schedule was then re-tested on a further five women and was found to be satisfactory. Both these studies were carried out by the researcher.

4.2.1.1.2.1.5 Research Instrument

For the purpose of this survey a structured interview schedule was used (See Annexure B).In order to ensure that the necessary information was obtained, use was made of close-ended questions. Open-ended questions were used to allow the participants opportunity to express their views. The interview schedule, as opposed to the questionnaire technique, was selected because of the high illiteracy rate of the patients delivering in the maternity unit. Data collected related to demographic data, previous facilities used for maternity care and reasons for choosing this hospital for the current pregnancy, patients' expectations and perceptions relating to care received during pregnancy, labour and the puerperium, information given in the ante-natal and post-natal periods and whether use was made of the ante-natal classes offered.

4.2.1.1.2.1.6 Data Collection

Interviews were conducted after the birth of the baby. For ethical reasons, such as the need to accommodate the exhaustion following delivery, participants were interviewed at least eight hours after delivery and in the case of participants who had delivered by means of a Caesarian Section a minimum of 24 hours later. Because of the problem of illiteracy, participants were asked to give verbal consent to being interviewed. In the case of participants under the age of 18 years, the consent of a parent or guardian was sought.

4.2.1.1.2.1.7 Use of a Field Researcher

The interview schedule was translated into Zulu to facilitate the communication process. To facilitate data collection and communication a research assistant was used.

The researcher would have preferred to use a registered midwife for this purpose. The advantage being that she would have been familiar with the terminology and therefore better able to probe questions and answers. A possible disadvantage was that being a midwife, the participants may have given her the answers they felt that she expected. To overcome this possibility, the assistant would have been asked not to wear her uniform and to introduce herself as a research assistant and omit the fact that she was a midwife. However, such a person could not be found. A school-teacher with limited research knowledge was chosen for her linguistic abilities. She translated the schedule into Zulu. When the schedule was translated the researcher consulted with the translator as to whether the wording that was used was the most appropriate in terms of culture and cultural understanding. The translated version was then read back to the researcher by a Zulu midwife in order to check for accuracy. The research assistant was given training regarding the use of the interview schedule by the researcher. She was given a typed copy of the introduction she was to use when approaching a participant and asking for permission to interview her (see Annexure C). The assistant was taught the necessity for and means of probing answers when conducting interviews. It was also impressed upon her that the participant had the right to withdraw from the interview at any time. Before accepting the position, the assistant and researcher agreed on a sum of payment for each completed interview. The assistant was informed of the number of

interviews required and the time demands which it would place on her. The potential to fake interviews is always a possibility when using an assistant to collect information. Hildebrandt quotes Fowler (1993:150) who states that "the key goal of the training must be to develop a mutual understanding and "ownership" of the effort." The assistant was therefore fully informed of the nature of the study. During the periods of data collection there was daily communication between the researcher and the assistant and feedback on the day's interviews. Some interviews were observed by the researcher in order to ensure inter-rater reliability and accuracy in the interview technique.

4.2.1.1.2.2 The Community Setting

To further assess the community's needs four focus groups were conducted with women in the community. The purpose of the focus group was to determine womens' perceptions of their health needs. In a World Health Organization report, Mutambirwa states that the health worker's syllabus should be based on information gathered from surveys of local women's knowledge, perceptions and views (WHO 1987:7).

A focus group is a group interview in which individuals are assembled for a group discussion, led by an interviewer. The interviewer is guided by a written list of topics to be covered. The advantage of the focus group is that the interviewer obtains the opinions of many individuals in a short time period. The disadvantage is that some people feel uncomfortable about expressing their views in front of others (Polit and Hungler 1991). Krueger (1994:10) says that "the focus group interview works because it taps into human tendencies." He goes on to say that the intent of the focus group is to promote self-disclosure and to accomplish a specific purpose through a defined process. He (1994:14) considers the purpose to be "... to obtain information of a qualitative nature from a predetermined and limited number of people." Kitzinger (Reed and Payton 1997:765) defines focus groups as "... group discussions organised to explore a specific set of issues.... The group is 'focused' in the sense that it involves some kind of collective activity." Krueger (1994:16) describes the characteristics of the focus group as follows:

- people

- assembled in a series of groups
- possess certain characteristics
- provide data
- of a qualitative nature
- in a focused discussion.

The purpose of the group is not to reach consensus or to make decisions (Krueger 1994). Krueger (1994:34) views the advantages of focus group interviews as:

- a socially oriented research procedure;
- having a format that allows the interviewer to probe;
- having high face validity;
- being relatively low in cost;
- providing speedy results, and
- enabling the researcher to increase the sample size of qualitative studies.

Reed and Payton (1997:766) concur with Krueger. They write that "the perceived advantages of focus groups in marketing research seem to be largely about cheapness, speed and flexibility." They also state that it is possible that statements made in a group are less constrained than those made in individual interviews. Goldman (Reed and Payton 1997:766) argues that focus groups create greater spontaneity than individual interviews.

Krueger (1994:34) describes the limitations as:

- the interviewer having less control in the group interview as compared with the individual interview;
- data being more difficult to analyse;
- requiring carefully trained interviewers;
- groups varying considerably in their unique characteristics;
- groups being difficult to assemble, and
- discussion which must be conducted in an environment conducive to conversation.

Reed and Payton (1997:766) state that main criticism of focus groups in the marketing literature relates to their lack of "representativeness" and hence to doubts about validity. They go on to quote Kitzinger who has stated that the nature of group interaction is not always

evident in the written report. Reed and Payton (1997:766) suggest that this may be due to difficulties in analytical methods and reporting strategies. Agar and MacDonald (Reed and Payton 1997:767) have criticised the use of focus groups as "stand-alone" methods. They believe that focus groups must be interpreted in integration with other ethnographic methods.

Krueger (1994:17) states that focus groups are usually composed of six to ten people, although as few as four and as many as 12 have been used. He states that the size of the group is really dominated by two factors. Firstly, it must be small enough to give everyone opportunity to share insights and secondly, it must be large enough to obtain a range of perceptions. The number of focus groups which should be conducted is guided by the information obtained. When little new information is forthcoming, then there is little value in continuing with additional groups (Krueger 1994:88). Krueger (1994) suggests evaluating after the third group. He does stress that the number of groups that may be needed is influenced by several factors, inter alia, the heterogeneity of the group, the topic of discussion and differences that reflect social and ethnic diversity. In this study the groups would be homogeneous and the topic of discussion was not sensitive in political or religious terms. It may be considered sensitive in personal terms , but the individual respondents shared information voluntarily and were free to leave the group should they so wish.

The focus group interviews were tape- recorded using a small battery operated recorder. The interviews were conducted and transcribed verbatim by the researcher. In addition to the recordings, use was also made of field notes. Porter (1996:119) describes field notes as observations that the researcher writes manually. They include detailed observations of situations and interactions in the field. Krueger (1994:147) says that they may include observations of the group such as silent agreement, obvious body language, indications of group mood or contradictory statements. Wilson (1993:222) identifies three types of field notes - observational notes, methodological notes and personal notes. She distinguishes them as follows:

- observational notes contain the who, what, where and how of a situation. They contain as little interpretation as possible;

- methodological notes are instructions to oneself, and
- personal notes contain the researcher's reactions, reflections and experiences.

The researcher made use of Porter's description and guidelines of field notes in this study. Payment or reward for participation in the group is suggested (Krueger 1994). In this study, all the women who participated in the groups were given a small gift at the end of each group.

4.2.1.1.2.2.1 The Sample

The focus groups were determined by collecting the residential areas given in the addresses of the women who delivered at the Johannesburg Hospital's maternity unit. The addresses given over a six month period were analysed. The frequencies were then used to determine the key areas which should be used to conduct the focus groups. These were then grouped into four larger areas. All the inner city street addresses formed one area; Hillbrow and the suburbs immediately adjacent to it formed another area; Alexandra addresses formed a third area and the addresses to the north of the hospital formed the fourth area. (See Annexure D for a map of the areas.) This technique has its limitations as it is known that many of the addresses given by the women are false. However, it is the only means by which areas could most closely be identified for inclusion in the study. Thus women who did not live in these areas of Johannesburg or who gave addresses outside of Johannesburg were excluded from the study.

4.2.1.1.2.2.2 Description of the areas.

Site A. This site is an inner city suburb called Hillbrow. During the apartheid era Hillbrow was considered to be the centre of night life with its night clubs and discotheques. The suburb is characterised by high rise buildings and shops that provide for everything from food to clothing, in its traditional form as well as the modern in its art deco form. Pavement cafes and art in every form create a street life. During the apartheid era the suburb was mainly inhabited by students, artists and young couples. It did have a fair proportion of elderly residents and it was not unusual to find that these people had lived there most of their lives and had no intention of leaving the area. With the abolition of the Group Areas Act the face of the suburb

has undergone a marked change. People of all races and nationalities have flooded into the suburb. Many illegal immigrants find refuge there. These factors have resulted in a transient population. The flats are occupied by more than one family, so that overcrowding has become a key issue. Babies and children are left in the gutters and the street children "earn" their living in various ways, such as acting as parking attendants. Crime, violence and poverty are the hallmarks of the suburb. The suburb's night life has undergone a change and is now characterised by prostitution and excessive use of alcohol and drugs. Many of the suburb's entrepreneurs have moved their businesses out of the area and have been replaced by small business developments. These developments sell food of all kinds, varying from fruit and vegetables to cooked foods, clothing and art. The move of big business from the suburb has resulted in large office blocks standing vacant. These buildings have either been vandalised or occupied by illegal tenants. The suburb is the centre of the Hillbrow Community Partnership in Health Personnel Education project in primary health care - a project of the Kellogg Foundation. Community groups represent the residents in various fora and there appears to be a sense of pride in their area.

Site B. Alexandra is an informal settlement to the north-east of the city. It has an approximate population of 500,000 (personal communication). It is difficult to accurately determine the population because of the mobility of the residents and because of the number of informal settlements. Housing varies from well built homes to shacks. A tributary of the Klip River runs along one of its borders and during heavy rains this spruit (small river) frequently comes down in flood. This results in people having to be evacuated from their informal houses and the loss of material goods. The roads of Alexandra are of various types with some being tarred and others being narrow sand roads. The area has a Health Centre which operates under the auspices of the University of the Witwatersrand. A number of satellite clinics are affiliated to the Health Centre. During the apartheid era the Health Centre was frequently under the surveillance of the police for people being treated for gunshot wounds and people involved in other subversive activities. Professionals working at the Centre were accused of sheltering wanted persons. It was not unusual for the police to raid the Centre looking for these persons

and for their medical records. The Centre operates as a primary health care centre and provides maternal and child services and adult care. The casualty and the obstetric unit provide a twenty-four hour service, but apart from the obstetric unit there is no provision for in-patient care. Should a patient require hospitalisation he\she is referred to one of the hospitals which surround the township.

Site C. The inner city area. This area has undergone a change in keeping with most of the cities in the world. It was the centre of big business and home to the major names in shopping. Hotels provided accommodation for business men and this was the area which tourists sought. However, all of this has now moved to the upper class northern suburbs and the city has become an area that is considered unsafe especially at night. Rates of theft, muggings and crime in its various forms are high. Bank robberies have become so frequent that some banks have chosen not to open on certain days of the week. Businesses are frequently robbed. The inner city does provide accommodation for many people in high rise buildings. Street vendors ply their goods during the day and these vary from fruit and vegetables, to cooked foods and to curios and jewellery. Overcrowding, poverty and crime are the hallmarks of the inner city. While the business centre has been run down, sex shops, escort agencies and dubious hotels abound.

Site D. A middle class suburb. This area is a more affluent middle class suburb to the north of the city. It is characterised by large modern homes built on quarter acre stands. The roads in the area are all tarred. Social amenities include primary schools, shops, churches and restaurants. Health facilities in this area are mainly private in the form of general practitioners and dentists rooms. The owners of the properties usually commute to work somewhere outside of the suburb. They offer employment to women in the form of domestic work. These women often live on the premises and therefore use the hospitals within the city.

The purpose of the study was explained to the participants and their verbal consent was obtained. (See Annexure E for information given to participants and Annexure T.)

4.2.1.2 SECTION B - REGISTERED MIDWIFE

Input into the curriculum is provided by the faculty staff and material resources available to them as well as by the personnel in the practice areas. In this section the qualifications of the faculty staff and its resources will be described. It will also describe the opinions of the midwives working in the Johannesburg Hospital's maternity unit.

4.2.1.2.1 Research Design

A survey method was used to determine the beliefs of midwives regarding needs of pregnant women and their perceptions of their roles in meeting these needs.

4.2.1.2.2 Research Instrument

A self-administered questionnaire was designed, making use of both open and close-ended questions. This method of data collection was been selected because it allowed the participant a degree of freedom of expression and she could complete it in a time suitable to her - given the work loads of the wards, time for individual interviews would have been difficult to arrange. Data collected related to demographic data; perceptions of patients needs; perceptions of the midwife's role and function and the degree to which midwives perceive themselves as change agents in the health care services and in the health of women. Information was give to the respondent in a covering letter (see Annexure F).

4.2.1.2.3 Validity

The questionnaire was sent to five experienced midwives, three of whom are also researchers. In this way the instrument was subjected to face and content validity and its reliability was assessed. Their comments were noted and required that some of the questions have additional categories e.g. Questions 1, 4.1, 4.2, 8.1, 8.2, 8.3 and 9.

4.2.1.2.4 Population

The population consisted of all the registered midwives working in the hospital's maternity section, viz. 102.

4.2.1.2.5 Sample

The sample comprised the entire population, as the questionnaire was to be administered to all the registered midwives working in the maternity section.

4.2.1.2.6 Pilot Study

The questionnaire was tested by administering it to ten midwives working in another government maternity unit in the same city. This unit is similar in terms of patient population and staff. They were asked to complete the questionnaire and to identify any questions which lacked clarity. Eight questionnaires were returned and there did not appear to be any problems in its use. Before the pilot study was undertaken permission was sought and obtained from the provincial health administration and the superintendent of the hospital where the pilot study was to be conducted. (See Annexures L and M.)

4.2.1.2.7 Administration of the questionnaire

The researcher attended a charge sisters meeting on a Monday morning. She explained the purpose of the questionnaire and how it fitted into the broader research. She also assured them that confidentiality and anonymity would be maintained and that the questionnaire would take approximately 20 minutes to complete. Each charge sister took sufficient questionnaires for the registered staff working in her ward. They also had the researcher's telephone number should any difficulties be encountered. The questionnaires were to be returned the following Friday. The response rate was poor - 30 completed questionnaires were returned. Reasons attributed to this were that it was the end of year lunch and staff were either involved in preparations or had simply forgotten. A number of staff were on leave. Five weeks later the researcher followed up the collection of data. She was given the opportunity to use an in-service meeting, which as many staff on duty as possible were supposed to attend. The researcher also provided a tea for this meeting.

Once again, the researcher explained the purpose of the questionnaire. Participants were given time to complete the questionnaire there and then. Some participants took questionnaires back to the wards for colleagues who had not been able to attend the meeting. These were followed

up. In order to improve the response rate, the researcher visited the wards once a week for two weeks at approximately 19:00. In this way she could approach day and night staff in an attempt to follow up any who had not had a questionnaire or who still had one in their possession. The final response rate was 66 of 102. However, two were incomplete and were therefore discarded. Thus the response rate was calculated as 64 or 62,7 %.

Throughout the data collection procedures the researcher stated that participation in the study was voluntary and that respondents were free to withdraw from the study at any time.

4.2.1.3 SECTION C - CURRICULUM

The current curriculum process was evaluated by obtaining the opinions of the students. A profile of the students in the programme and their learning needs was obtained. The current curriculum extends over four years of study. The degree enables them to obtain four professional registrations, i.e. as a general nurse, psychiatric nurse, community health nurse and as a midwife. During the four years of study the students are required to complete 2380 hours of general nursing practica, 320 hours in community nursing and 600 hours in each of psychiatric nursing and midwifery. The academic curriculum is traditional in its approach in that it is content and lecture driven. There is overlap in subject matter. It is in line with the traditional approach to nursing curricula of the 1960s - 1970s where there is a clear distinction between the basic sciences and the nursing subjects. Subjects such as chemistry, physics and psychology which are taught in the first year of study tend to be taught as pure sciences rather than at an applied level. Human behavioural science and nursing are the remaining first year subjects and here application appears to be somewhat better. Community health nursing and nursing are taught in the second year of study together with microbiology, physiology and anatomy. Microbiology and anatomy are content driven in their approach, while physiology is taught at an applied level. In the third year of study two new subjects are introduced, viz. midwifery and psychiatric nursing. The remaining subjects are nursing and a second course in psychology. The fourth year of study is devoted to the four nursing disciplines - nursing, community health nursing, psychiatric nursing and midwifery. Students tend to perceive the basic sciences as being of greater importance than the nursing subjects.

4.2.1.3.1 Population

The population consisted of all the students registered for the B.Nursing degree at the University of the Witwatersrand in 1994. The total number was 91 students.

4.2.1.3.2 The Sample

The sample comprised the entire population as the questionnaire was to be distributed to all the students registered for the B.Nursing degree in 1994.

4.2.1.3.3 Research Design

A survey method utilising a self-administered questionnaire was used.

4.2.1.3.4 Research Instrument

This section of the study formed part of a bigger survey being undertaken in the faculty. The purpose of which was to determine students perceptions in the various disciplines regarding the relevancy of the courses taught to their specific career choice. The questionnaire was designed in consultation with faculty from other disciplines in an effort to standardise the content being evaluated across the disciplines. The questionnaire was adapted to the year of study (see above). Data collected related to the student's educational background, opinions regarding the curriculum content and clinical practice needs. The questionnaire made use of both open and close-ended questions and was administered during class time in order to improve the return rate. Only the third and fourth year questionnaires which are relevant to this study are included with their covering letters (See Annexures G and H).

4.2.1.3.5 Pilot Study

As the sample comprised the entire population, it was not possible to test the questionnaire on the current students. In an attempt to assess the clarity, the questionnaire was tested on four graduands who had completed the degree at the end of 1993. No alterations were required.

4.2.1.3.6 Additional Questionnaire

An additional questionnaire was administered to the last group of students graduating from the traditional programme. This questionnaire was added to the study in order to clarify some of the statements made by the graduands and the nursing supervisors in the focus groups relative to outcome. It was an attempt to obtain the students' perceptions of some of the statements made, e.g. that learning had not taken place in the clinical settings outside of the hospital.

4.2.1.3.6.1 Population

The population consisted of all the students registered for the B. Nursing degree at the University of the Witwatersrand in 1997. The total number was 85 students.

4.2.1.3.6.2 The Sample

The sample comprised the final year students in the B. Nursing programme. There were 20 final year students.

4.2.1.3.6.3 Research Design

A survey method utilising a self-administered questionnaire was used.

4.2.1.3.6.4 Research Instrument

A self-administered questionnaire was designed. This questionnaire attempted to probe some of the issues raised in the focus groups with past graduands and nursing supervisors (vide 4.2.1.3.6 above.) Data collected related specifically to students opinions regarding the midwifery course. The questionnaire made use of both open and close-ended questions. It was administered at the end of their examination period, when they attended for their viva with the external examiner. The students were approached individually, as they arrived for the viva and asked to complete the questionnaire. They could complete it either before or after the viva. At times there was more than one student in the process of completing the questionnaire, but discussion between them, regarding the questionnaire, did not appear to occur.

Information was given to the student in a covering letter (see Annexure I).
Due to their practical allocations, time did not permit that a focus group be organised with the students.

4.2.1.3.6.5 Pilot Study

Time did not permit that this questionnaire be subjected to a pilot study. However, a similar version had been used previously by the researcher to collect information. This instrument had proved to be satisfactory.

4.2.1.4 SECTION D - OUTCOME

In order to determine the outcome or product of the programme past graduands who had entered midwifery practice were interviewed. The purpose of interviewing these graduands was to try to determine their perceptions of their knowledge base as beginning practitioners and how they perceived the curriculum in preparing them for this role. Graduands were interviewed in two focus groups. The first group was used to identify issues which needed to be probed and discussed more fully.

Outcome was also evaluated by interviewing service managers and charge sisters, who were in a supervisory position to these graduands. They were interviewed to determine the standard of practice of these graduands and to obtain their perceptions of the midwifery curriculum.

4.2.1.4.1 Data Collection

4.2.1.4.1.1 Graduands in Midwifery Practice

Two focus groups with graduands were held. In the first group there were three graduands who had entered midwifery practice was held. The number was small because students enter diverse areas of practice on completion of their degree and few remain in practice at the hospital. At the time that data in this area was being collected there were only three graduands in midwifery practice at the hospital. Venter (1995) describes focus groups as being useful for finding out more about students from their perspective.

As the researcher knew the participants as students the possibility that they would not discuss and give criticism of her course existed. In order to promote an unbiased climate for the group she provided a light lunch for the participants before the group. This gave the participants opportunity to talk informally and to get to know one another beforehand. The researcher had always had good relationships with these graduands, both as students and after graduation. She joined in the lunch time discussion, enquiring about their families and colleagues.

The purpose of the group was explained to them and they were asked to be as honest as possible about their perceptions and feelings of the course. The graduands were asked whether the programme had met their needs and where they felt that there were deficiencies in the programme. According to Stufflebeam this is best done at one year post-graduation (Clark et al 1983). However, this was not possible as the number of graduands available was too small. Those available varied in their period of post-graduation experience from one year to four years. (See Annexure J for subject information sheet). As the researcher tended to become a participant in the group, another group was subsequently planned.
The procedure used for the data collection in these focus groups has already been described above (vide 4.2.1.1.2.2 p 102).

4.2.1.4.1.2 Supervisors of care-givers

Two focus groups of service managers and charge sisters from the maternity unit were held. The first group served to identify issues which needed further probing. The purpose of these groups was to seek their opinions regarding graduands abilities and preparedness for practice on entry into the profession as registered midwives and to obtain their perceptions about the midwifery curriculum, such as content deficits and its structure. The focus group was selected as the method of data collection for the reasons given above. The group was asked to respond to curriculum deficits and not to individual student's deficits. Therefore, names of students should not be used. (See Annexure K for subject information sheet).
The procedure used for the data collection in this group has already been described above

(vide 4.2.1.1.2.2 p 102). Reed and Payton (1997) make the point that much of the literature on focus groups assume that group members do not know each other, but that in nursing studies which involve staff members, not only do they know each other, but they may well have done so for a considerable period of time. They go on to say that this changes the group dynamics and should be considered when using this technique. This applies to some degree in this study. While they did not work together in the same unit, they did work together in the broader rendering of the service.

4.2.1.4.1.3 Pilot Study

Pilot studies were not conducted for the focus groups held with the women in the community, the graduands or the nursing supervisors. This is because pilot studies are viewed as being inappropriate in qualitative research (Morse 1997). Morse (1997:323) argues that pilot studies may "... actually hinder inquiry." She states that qualitative research depends on data being saturated and this, by definition, cannot occur in pilot studies. Pilot results could present "inaccurate, misleading, or incomplete information ..."

4.3 VALIDITY AND RELIABILITY.

Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Polit and Hungler 1991:374). Further statistical testing was not considered appropriate.

4.3.1 Quantitative aspects of the study

There are three types of validity, viz. content, criterion-related and construct validity. The midwives questionnaire, the patient interview schedule and the student questionnaire were subjected to content validity by consulting with experts in the fields of midwifery and education.

Reliability of an instrument refers to the degree of consistency with which it measures the attributes it is supposed to be measuring. Reliability is improved by virtue of the

heterogeneous nature of the samples that were used. Data collection methods were selected to improve reliability, e.g. an interview schedule for patients because of the high incidence of illiteracy and a questionnaire for the midwives to allow them opportunity to express their opinions more freely in an anonymous format as compared with an interview situation.

4.3.2 Qualitative aspects of the study

Miles and Huberman (1994:38) state that in qualitative research the issues of reliability and validity depend largely on the skills of the researcher. They go on to say that some markers of a good qualitative "researcher-as-instrument" are:-

- some familiarity with the phenomenon and the setting under study;
- strong conceptual interests;
- a multidisciplinary approach, as opposed to a narrow grounding or focus in a single discipline, and
- good "investigative" skills - the ability to draw people out and the ability to ward off premature closure.

With reference to internal validity they state that some relevant queries are:-

- how context-rich and meaningful are the descriptions?
- does the account "ring true", make sense, seem convincing or plausible for the reader?
- are concepts systematically related?

Relevant queries for external validity: -

- are the characteristics of the original sample of persons, settings, processes fully described enough to permit adequate comparisons with other samples?
- have limiting effects of sample selection, the setting, history and constructs used been discussed? (Miles and Huberman 1994:279).

4.3.2.1 GUBA'S MODEL OF TRUSTWORTHINESS

Agar (Krefting 1991) suggested that the terms reliability and validity are relative to

quantitative research and do not fit the details of qualitative research. Researchers have suggested that alternative models are necessary in qualitative research. Krefting (1991) has described Guba's Model of Trustworthiness. This model is based on the identification of four aspects of trustworthiness. These are relevant to both quantitative and qualitative research and are:

- truth value,
- applicability,
- consistency, and
- neutrality.

These aspects are described as follows:

- **truth value** seeks to determine whether the researcher has established truth in the findings for the subjects and the context in which the study was undertaken. In qualitative research, truth value is obtained from the discovery of human experiences as they are lived and experienced by informants. Lincoln and Guba termed this credibility (Krefting 1991:215).
- **applicability** refers to the degree to which the findings can be applied to other contexts and settings. This aspect has met with criticism from Sandelowski who says that every situation is unique and applicability, therefore, is not relevant to qualitative research (Krefting 1991:216). Guba has suggested the term fittingness or transferability instead. "Research is said to have met this criterion when the findings fit into contexts outside the study situation that are determined by the degree of similarity or goodness of fit between the two contexts" (Krefting 1991:216). She (1991:216) goes on to quote Lincoln and Guba who state that as long as the original researcher presents sufficient descriptive data to allow comparison, the problem of applicability has been addressed.
- **consistency** refers to whether the data would be consistent if the procedure were replicated with the same subjects. Krefting (1991:216)states that variability is expected in qualitative data and consistency is defined in terms of dependability. Consideration must be given to the fact that qualitative research looks at the range of

rather than the average experience.

- **neutrality** refers to the freedom from bias in the research procedures and results. Lincoln and Guba shift the emphasis of neutrality from the researcher to the data. They suggest that confirmability be the criterion of neutrality and that this is achieved when truth value and applicability are established (Krefting 1991:217).

Strategies have been suggested to increase the trustworthiness of qualitative research. These are efforts to increase rapport with respondents, the use of triangulation in data collection methods, member checking and peer examination. All of these techniques were applied in this study. The researcher, inter alia, introduced herself to the groups, explained the purpose of the group and gave an estimate of the length of time it would take to conduct the group. She familiarised herself with the first names of the group members, in order to be able to address them by name. The respondents were advised that they were free to leave at any time should they so wish. Data collection subsumes a triangulated approach in that use is made of interviews, self-administered questionnaires and focus groups. The transcriptions of the graduands and nursing supervisors groups were given to a group member for member checking and peer examination was achieved through discussion of the research process and findings with impartial colleagues. She attempted to enhance credibility during the focus groups by reframing and repeating questions. She used the same approach in each group and the same sequence of questions. In order to ensure transferability, women were interviewed in a hospital setting and in community settings. The hospital based sample included women of all ages and parity and the community based groups included women of all ages, irrespective of their experiences of the health care services.

The researcher was conscious of the influence of reflexivity in the study. "Reflexivity refers to assessment of the influence of the investigator's own background, perceptions, and interests on the qualitative research process" (Krefting 1991:218). This was possible because the researcher was in the position of being a novice as qualitative researcher. In order to establish her credibility, the researcher consulted with those more expert in the field. To this end she

consulted with colleagues within the university and with internationally recognised experts in the field from Canada and Australia. However, she is also an educator concerned in the development of an appropriate curriculum for women's health. In addition she is also a nurse and midwife. These aspects form the core of the study and thus her background and personal perceptions could create a bias. The researcher attempted to overcome this by reflecting frequently on her thoughts and feelings which were generated by the various findings.

4.4 ETHICAL ISSUES

4.4.1. Permission was sought and granted from the Gauteng Health Authorities and the Johannesburg Hospital authorities to interview staff and patients and for access to statistical records. (See Annexures L and M).

4.4.2. Verbal consent was obtained from patients and midwives to complete the relevant questionnaires.

4.4.3. In the case of the focus groups, verbal permission to interview and record the interview was obtained from the participants. The participants were assured of anonymity. The tapes would be destroyed after they had been transcribed and no individual would be identified in the groups.

4.4.4 An information sheet and covering letters accompanied the patient interview schedule and the midwives and students questionnaires respectively. (See Annexures C, F, G, H and I).

4.4.5. Permission was obtained from the Committee for Research on Human Subjects of the University of the Witwatersrand. Protocol Number M 950318 (see Annexure N).

4.5 ANALYSIS OF DATA

The triangulation process, with quantitative and qualitative methodologies, facilitated the collection of rich data. It furthermore, ensured comprehensiveness and inclusivity of the data. Analysis of quantitative data was done manually and bivariate analysis was done using the SAS version 6.12 package. Descriptive statistics of results are used where appropriate. Significance testing was applied where appropriate. Analysis of the qualitative data was done

using the eight steps suggested by Tesch (Creswell 1994:155). These are:

- Get a sense of the whole by reading through all of the transcriptions.
- Take one at a time and look for the underlying meaning.
- Cluster similar topics.
- Abbreviate the topics as codes and apply these to the appropriate segments of the text.
- Reduce the topics into categories.
- Make a final decision on the abbreviation for each category.
- Assemble the data material belonging to each category.
- If necessary, recode existing data.

This process was aided by the interviews being transcribed verbatim by the researcher. An expert reviewed and compared the raw data. The researcher and the expert reached agreement on the main categories and sub-categories.

Burnard (1991:461) states that no one method of analysis can be used for all types of interview data. He goes on to quote Glaser and Strauss (1967) who write that in the analysis of qualitative data is the problem of what to leave out of the analysis of the transcript. All the data should be accounted for under a category or sub category, in order to ensure inclusivity.

4.6 PART B - DEVELOPMENT OF PROBLEM-BASED CURRICULUM

This part of the methodology was not included in the conceptual framework for the development of a curriculum in women's health because the workshops had begun prior to the commencement of this study. However, they were an important part of the change process and the researcher was a senior member of the team in this change process. This part is therefore being included for completeness.

The research process for this can be described as follows.

4.6.1 RESEARCH DESIGN

A staff retreat was held. This extended over five days which were broken down into two two-day and one one day workshops. The group comprised all the full time academic staff. The

two day workshops were led by a retired dean of medicine who had a keen interest in medical education and problem-based learning in particular. One two day workshop focused on community-based education and the second two day workshop on problem-based learning. During these workshops literature was reviewed, there was reflection on the current curriculum in terms of its strengths and weaknesses and its outcomes. There was peer review of the individual courses in which positive and negative aspects were identified and discussed. During the one day workshop staff met without the facilitator and deliberated an integrated curriculum based on a health to illness approach. Having debated community-based education and problem-based learning in the previous workshops, the use of these concepts in an integrated curriculum were discussed. It was considered essential that the entire staff approve this shift in paradigm and commitment was called for, and obtained, from all the staff.

The process was taken further in the development of a departmental philosophy and concept definition for the overall curriculum. In relation to the course for women's health, the researcher took the process forward by developing a course philosophy and consulting with experts in the fields of women's health and problem-based learning, both nationally and internationally.

4.7 CONCLUSION

In this chapter the research design based on the conceptual framework has been described. The necessary considerations and preparations for the data collection process have been identified and discussed.

CHAPTER FIVE

FINDINGS AND DISCUSSION OF FINDINGS

Work is love made visible.
And if you cannot work with love but only with
distaste, it is better that you should leave your
work and sit at the gate of the temple and take
alms of those who work with joy.
(Gibran 1997:34)

In this chapter the findings of the research will be described. In Part A the findings will be presented utilising the concepts of the conceptual framework, viz. the environment, registered midwife, curriculum (with reference to midwifery) and outcome (with reference to the newly qualified midwife). Under the concept of environment the statistics of the maternity unit for one year will be presented, as well as the results of the patient interviews and the focus groups held with women in the community. The concept of registered midwife will describe the human and material resources in the faculty and the opinions of registered midwives who provide input in the practical situation. The concept curriculum will be described utilising the evaluation of the programme as seen by all the students in the programme in 1994 and those who completed the programme in 1997. The outcome will be described using the focus groups held with past graduands and their supervisors. In Part B the development of the problem-based curriculum will be described. The findings will follow the methodology as set out in chapter four.

The findings will be described under the following headings and sub-headings:

5.1 PART A - SECTION A

5.1.1 Findings relating to environment - the hospital setting and patient interviews.

5.1.2 Findings relating to environment - the community focus groups.

5.2 SECTION B

5.2.1 Description of Resources

5.2.2 Findings relating to the registered midwife - questionnaire given to registered midwives.
5.3 SECTION C
5.3.1 Findings relating to the curriculum
5.3.1.1 Questionnaire given to all students in the B.Nursing Programme
5.3.1.2 Questionnaire given to final year students
5.4 Section D
5.4.1 Findings relating to outcome
5.4.1.1 Focus groups held with graduands
5.4.1.2 Focus groups held with nursing supervisors.
5.5 PART B - The Development of the Problem-based Curriculum.

5.1 PART A - SECTION A

This section describes the environment in terms of the hospital and community settings. Postpartum women were interviewed in the maternity section of the Johannesburg Hospital and women were interviewed in four focus groups in the community setting.

5.1.1 FINDINGS RELATING TO ENVIRONMENT - THE HOSPITAL SETTING AND PATIENT INTERVIEWS

5.1.1.1 THE SETTING

The hospital in which the study was undertaken and in which the students obtain their practical learning opportunities is a large 900 bed academic hospital. It provides services for obstetrics and gynaecology, paediatrics, medicine and surgery. It has two casualties and three intensive care units. Specialist services in the form of ophthalmology, ENT and orthopaedics are also provided and therefore a number of specialised operating theatre suites are included in the complex. The hospital is situated to the north of the city. Transport to the hospital is not easily accessible and visitors to the hospital are dependent on own transport, taxis or special "hospital buses". The hospital is designed to incorporate three hospitals and is divided into five blocks. The obstetric hospital forms the first block . The obstetric unit has an ante-natal

clinic, labour ward and transitional baby unit, two post-natal wards and an ante-natal ward. A premature baby unit is situated in the paediatric block of the hospital. The ante-natal clinic creates a friendly environment. The staff are warm and friendly. The labour ward is a large area and a clinical atmosphere pervades. Staff appear to be always busy, but once approached they endeavour to help. The post-natal wards are clinical in their decor, but the staff are helpful and friendly. The ante-natal ward is clinical in its decor and the staff are perceived as being unfriendly and unhelpful. This unit functions as a referral centre and hence its patient load is considerable. The fact that it provides care at primary care level through to tertiary care level is problematic and makes management difficult. Table 5.1 demonstrates the statistics for the labour ward for the year July 1995 to July 1996.

Table 5.1. Statistics for academic hospital: 1995-1996

Labour Ward	Aug. 1995	Sep. 1995	Oct. 1995	Nov. 1995	Dec. 1995	Jan. 1996	Feb. 1996	Mar. 1996	Apr. 1996	May 1996	Jun. 1996	Jul. 1996
Total Deliveries	647	638	542	522	538	617	622	694	644	725	702	659
Vaginal	498	475	390	370	410	466	487	503	473	512	525	481
Breech	7	8	4	5	8	11	8	14	10	19	21	8
Vacuum	16	12	7	10	4	8	12	18	20	20	12	11
Forceps	1	2	2	2	2	4	1	1	0	2	1	6
C/S	116	136	128	116	103	116	102	120	131	164	132	138
Abortions	9	6	10	19	11	12	14	18	9	8	12	9
Admissions	692	683	582	558	610	652	674	742	695	768	612	712
Unbooked	92	81	93	100	91	115	143	186	113	110	127	92
B.B.A.	27	12	24	17	17	18	18	18	30	17	20	14

The gynaecology department within the block manages women with carcinomas of the cervix and the ovary, inter alia. The numbers of women seen with these conditions is probably reflective of the general population. Cancer of the cervix is the most common cancer seen in women, comprising 17,8% of all cancers. "It is the most common cancer in black (33,7%),

and in coloured (24,5%), second most common in Asian (10,3%) and fourth most common in white women (3,5%)" (Epidemiological Comments 1997).

5.1.1.2 ANALYSIS OF PATIENT INTERVIEWS TO DETERMINE THE PERCEIVED NEEDS OF PREGNANT WOMEN DURING PREGNANCY, LABOUR AND THE PUERPERIUM (N = 250).

5.1.1.2.1. Age

The majority of the women (195) were between the ages of 18 and 31 years, with 56 being in the 25-27 year category. There were eight women in the 38-41 and two aged 42 and more.

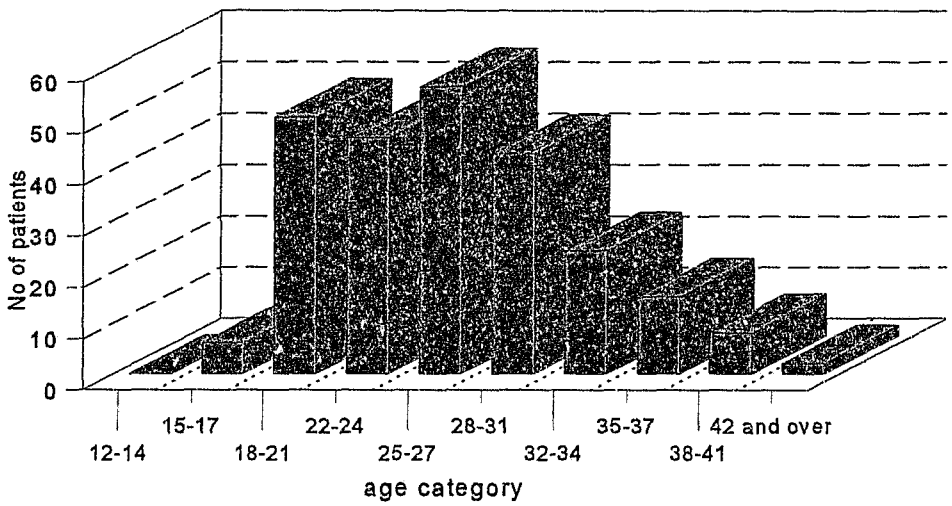


Figure 5.1 Number of patients in each age category (N-250)

It is of importance to note that there were ten women over the age of 38 years as this age group is more susceptible to having pregnancies which result in congenital abnormalities, e.g. Down's syndrome babies. They are therefore considered high risk patients. The researcher was surprised that there were no patients in the 12-14 year category, as in her practical experience

she had cared for several young girls in this age group. Figure 5.1 shows the number of patients in each age group.

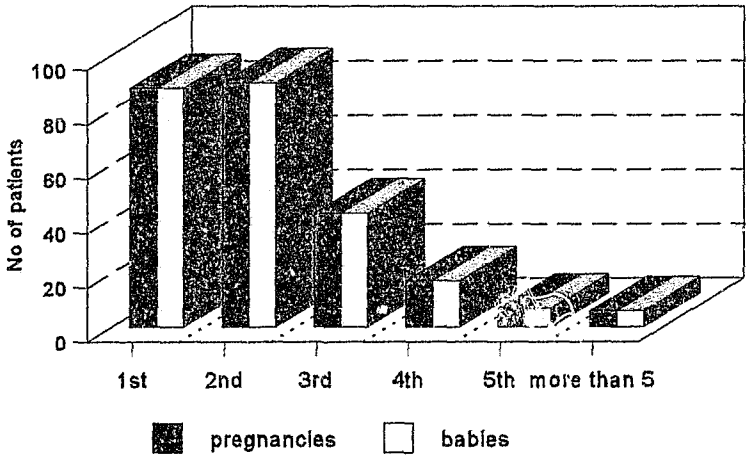


Figure 5.2 Number of pregnancies and babies per patient (N=250)

5.1.1.2.2. Pregnancy

The largest frequency distribution was second time pregnancies (90), with primigravidas (88) forming the next largest group. Thirteen women had their fifth or more babies. This finding is of importance as these women are more likely to be older and their parity together with their advanced age would put them into a high risk category. Figure 5.2 reflects the frequency of the number of pregnancies and babies for each patient.

5.1.1.2.3. Number of babies

The number of babies correlates exactly with the number of pregnancies experienced. (Figure 5.2). Questions 2 and 3 do not suggest that any abortions had been experienced in this group. This finding is questionable and may be explained by the fact that a spontaneous abortion may have occurred prior to the patient knowing that she was pregnant. It is also possible that

women may not have wanted to admit to an abortion, either spontaneous, therapeutic or procured.

5.1.1.2.3.1 Whether babies are alive or dead

Two hundred and thirty one patients reported that all their babies were alive. Only 19 patients reported that one or more of their babies had died. In the majority of cases women were unable to give the cause of death. Only in one instance was prematurity given as a cause of death. This finding is disturbing because some of the factors relating to death may be recurring conditions, e.g. prematurity.

When age was analysed against parity (number of babies) it was found that in the 15-17 year age group four women had had their first babies and one had already had her second baby. In the 18-21 year age group, eight women had had their second babies and in the 22-24 year age group seven had had their third babies. These findings are of importance for midwives for two reasons. Firstly, age of first coitus and age at first pregnancy have been shown to be significant factors in the aetiology of carcinoma of the cervix (Coppleson 1969). These women need to be advised about the importance of regular Papanicolaou smears. Secondly, contraceptive measures need to be fully discussed and explained to these women.

5.1.1.2.4. Place of previous deliveries.

For 88 patients this was their first pregnancy and so this question was not applicable. Most of the patients had had their previous babies in a hospital - 80 at this hospital and 97 at another maternity hospital. One patient had had a previous baby at a private clinic. Twenty-one patients had delivered in a clinic, while only four stated that they had had their baby at home. In this instance N does not equal 250 because some women responded to more than one category where this was not their first baby. These findings reflect the nature of the urban population interviewed. In the rural areas it is still customary to deliver at home under the care of a traditional birth attendant.

5.1.1.2.5. Reason for choosing this hospital.

Figure 5.3 reflects the reasons that the women gave for choosing to have their babies at this hospital.

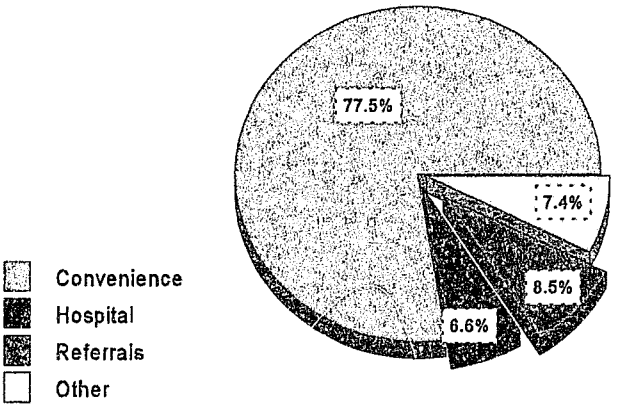


Figure 5.3 Reasons for choosing this hospital

The most frequently cited reason was the hospital's proximity to place of residence. This finding of accessibility is significant when one considers that this is a tertiary care hospital and the move in the health care services is towards a primary health care approach. Furthermore, fourteen patients chose this hospital for reasons relating to the hospital itself. Irrespective of the level of care, there is no other maternity unit in the geographical area from which the majority of the women come. Figure 5.3 shows that 77,5% (n=189) of the women chose the hospital for reasons relating to convenience, 8,5%(n=21) because they were referred, 6,6% (n=16) for reasons relating to the hospital itself, e.g. that it is a good hospital and that "proper" care was needed and 7,4% (n=18) for other reasons.

5.1.1.2.5.1 Number of weeks pregnant when booking into the hospital.

The majority of the patients were twenty weeks gestation or more when they booked into the ante-natal clinic. The late period of booking may be explained by the fact that many of the patients view "booking" as meaning that they have a bed booked for the actual delivery. Furthermore, when services were made free the clinic could not cope with the numbers. Patients had to be given a date on which to return for the booking visit. The booking list was so long that it often meant that the return date was very near to, or in some instances after the expected date of delivery. Table 5.2 shows the periods of gestation at which patients booked into the hospital.

Twenty-six percent, just over one-quarter, of the patients booked into the clinic between 20-24 weeks gestation. This may be a comm on perception among women to wait until the second trimester before "booking a bed". Less than ten percent had booked before the end of the first trimester of pregnancy. This is a period which is crucial to establishing accurate baseline data.

Table 5.2. Period of gestation at time of booking (N=250)

No. of weeks	N	%
8-10	4	1,6
12-14	13	5,2
16-18	8	3,2
20-24	65	26,0
26-28	39	15,6
32-34	24	9,6
36-38	27	10,8
39-40	16	6,4
referred in labour	9	3,6
unbooked	33	13,2
not sure	12	4,0
	250	99,2

5.1.1.2.6. Care that patients expected to be given during pregnancy.

This question proved to be difficult to probe. Many patients (74) linked care that they expected to be given to care that they expected to be given at home. When this was probed one patient said "care begins at home". This may be explained culturally, in which case it has significance for the care-giver. If the patient isn't getting this care at home it may influence her mental status and her health during the pregnancy. This links with the twelve patients who gave negative statements relating to the family and home situation. Therefore, care-givers should always enquire about the home situation in their routine assessments. It was also found that patients (43) expected to be "well looked after" or "cared for", but they could not elaborate on this. Just under half (107) of the patients linked the standard of care expected to the hospital's name and its academic status and therefore expected that care would be good . Six patients related their expectations to support and information and five compared the standard of care given at the hospital to the "poor" care they had received elsewhere.

5.1.1.2.7 Perceptions regarding information received during pregnancy.

In this question patients were asked whether they had received information relating to various aspects of antenatal care and labour. Table 5.3 reflects the responses to these concepts in terms of information received.

It is disturbing to note that 86% of patients stated that they had not received information on "danger signs in pregnancy" When this finding was subjected to further analysis it was found that four out of six of these women were in the 15-17 year age group, 45 in the 18-21 year age group, 38 in the 22-24 year age group and 47 in the 25-27 year age group. This finding becomes more frightening when one finds that 74 of these mothers were first time mothers, 77 were second time mothers and 33 were third time mothers. This finding may be partly explained by the communication difficulties which are a major problem in providing ante-natal care. However, if we are to empower women in self-care then this is an aspect which needs to be given considerable attention when providing health information. This finding may be suggesting the need for interpreters in the provision of health care. It is also an aspect that

requires emphasis in midwifery education.

Table 5.3. Information received during pregnancy (N=250)

	Concept	yes	%	no	%
7.1	your physical condition	245	98,0	5	2,0
7.2	your baby's condition	233	93,2	17	6,8
7.3	danger signs of pregnancy	35	14,0	215	86,0
7.4	breastfeeding	*220	88,0	29	11,6
7.5	signs of labour	242	96,8	8	3,2
7.6	what to expect during labour	239	95,6	11	4,4
7.7	preparation for labour	237	94,8	13	5,2
7.8	choices during labour	236	94,4	14	5,6
7.9	diet	33	13,2	178	71,2
7.10	sexual needs and responses	*223	89,2	26	10,4
7.11	development of the baby	242	96,8	8	3,2
7.12	personal hygiene	245	98,0	5	2,0
7.13	emotional changes and stress	77	30,8	173	69,2
7.14	AIDS and other infections and how they can affect the baby	240	96,0	10	4,0
7.15	parenting - how to cope with being a mother	246	98,4	4	1,6
7.16	caring for your baby	246	98.4	4	1,6
7.17	social services for pregnant women	201	80.4	49	19,6

* one did not answer these statements

Another disturbing finding is that 71,2% of women stated that they had not received

information regarding "diet". Lack of information regarding diet may be linked to the care-givers inadequate awareness of cultural influences on diet. Caregivers may lack knowledge about the methods of food preparation in the different ethnic groups. If the patient is gaining weight and does not appear to be anaemic, she may disregard this factor as needing attention. Dietary information, again, is an area which needs to be addressed for self-care. Many of these women are victims of hypertension in later life. Furthermore, it is an aspect in which women need to be empowered. Many of these women eat a very poor diet because of the cultural value that the men must eat first. This means that often women are left with very little in quantitative terms and then it is of little or no nutritional value. In addition, many mothers today are working mothers and rely on fast foods and sometimes even cooked foods that are sold on the streets. Further analysis of this aspect revealed that five of the six women in the 15-17 year age group, 38 in the 18-21 year group, 32 in the 22-24 year group, 37 in the 25-27 year group and 32 in the 28-31 year group had not received information about diet. This means that 144 women aged 31 and under had not received this information. Furthermore, 63 of these were first time mothers and 64 were second time mothers.

Midwives need to stress dietary information to mothers in the younger age groups and to primipara. It appears that the midwife cannot assume that the woman received this information in her first pregnancy and therefore this information needs to be reinforced in second and subsequent pregnancies.

This question did not probe the actual knowledge of the respondents.

5.1.1.2.7.1 Whether information given was understood.

237 (94,8%) patients stated that they understood the information which they had been given. Six stated that they had not and seven were unsure about this. Oakley (1993:35) reports on a study in which patients were asked whether they understood what the doctor had said, 95% of the patients stated that they had. She goes on to quote another study in which women were asked to give the meaning of common obstetric terms. A group of physicians were asked which

of the terms they would expect patients to understand. The results revealed an "overwhelming underestimation" by the physicians of the patients' ability to understand.

5.1.1.2.8. Attendance at antenatal classes.

It was disturbing to find that only 83 patients had attended antenatal classes and that 167 had not. Of the 83 women who had attended classes, 72 were between the ages of 18-31. The six in the 15-17 year age group had not attended the classes. This may suggest that the teenagers felt intimidated by attending classes with more mature women and it may reflect the need for special classes for teenagers. Of the 83 women, 29 were primipara and 31 were second pregnancies. The fact that only 29 of the total of 88 primipara (32,9%) in the sample attended classes needs attention. Fifty-two of the primiparas were in the 18-24 year age group. The women in this study are a disempowered group who would not be aware of their options. Midwives need to encourage these young women to attend the classes. It was not within the scope of this study to determine reasons why women do not attend antenatal classes. This is an area which requires further research. Ante-natal classes refer to health information, relaxation techniques and labour preparation classes.

5.1.1.2.8.1 If attended classes, number of classes attended:

Only five patients had attended the whole course, of either six or eight sessions. Eighteen patients had attended one class. This finding may be of some importance in that patients are "recruited" to the classes while they are waiting to be seen by the doctor or midwife. If they only attend once then perhaps the format of the class needs to be evaluated as it is possible that the class is not meeting needs. One patient said that she had attended nine classes and one that she had attended ten classes. This is explained by the fact that some women repeat classes if they feel unsure about content. However, in this instance it is also possible that the respondents were relying on memory and did not know the length of the course. Table 5.4 shows the frequency with which classes are attended.

Table 5.4. Number of classes attended (N=83)

No. of classes	N
one	18
two	25
three	21
four	9
five	0
six	2
seven	0
eight	0
nine	1
ten	1
whole course	1
not answered	5

5.1.1.2.8.2 Ante-natal class attended:

The majority of the patients (75) attended the class on the day of their clinic visit. At the time of the study, these classes were conducted by a physiotherapist and consisted of six sessions. The content of the course was as outlined below, but was condensed and did not give separate sessions to medical interventions and Caesarian Sections and she did not cover parenting. Only two attended on a Monday evening. This is a more specialised class and is meant to attract couples. This course was given by a registered midwife and consisted of eight sessions. The first session was an introductory evening and in this session feelings about pregnancy and parenting were explored. It also included an introduction to breathing and relaxation techniques. The next two sessions covered the three stages of labour. The fourth focused on the puerperium and baby care. The fifth was devoted to breast-feeding and the sixth to medical interventions during labour. An entire session was given to Caesarian Sections and the last was

a broad overview of parenting, that was meant to focus on realities, such as discipline. Breathing and relaxation techniques were practised and reinforced every week throughout the course (See Annexure O). The poor attendance at this class could be explained in terms of cultural values and the timing of the class needs to be assessed in that it may be felt unsafe to leave the hospital and travel home when it is dark and public transport is not readily available. Despite this explanation only six patients stated that they had attended a Wednesday afternoon class. This class is given in Zulu and the safety factor should not be an issue here. It appears that care-givers need to make most opportunity of the routine clinic visit. This requires serious consideration because with the increase in the patient load, the frequency between each visit for the low risk patient has been extended, meaning that in effect there is less time for health information sessions.

5.1.1.2.8.3 Whether times of classes are suitable:

Despite the poor attendance at the classes, 81 stated that the times of the classes were suitable and only two stated that they were not. It appears that patient motivation may be a factor in these findings.

5.1.1.2.8.4 Whether classes were useful:

Seventy-seven of the patients felt that the classes had been useful. Three stated that they were not and three were not sure.

One respondent stated that we need to educate employers. This is a valuable comment in that very often the patient has to take a day off to attend clinic. If she is allowed time off then the time she arrives back on duty is noted. This does not encourage the patient to extend her visit to the clinic for any purpose out of the essential. However, it must be borne in mind that the classes are held in the time that patients are waiting to be seen.

Some of the comments relating to the usefulness of classes could be divided into positive and negative comments. The positive comments related to the need to come to the hospital earlier

the next time so that they could start attending the classes earlier in the pregnancy (24) and that the partner should be invited to the classes. The negative comments referred to the preference not to use the hospital, but would prefer home visits or a nurse in the community (5); that the classes were taught at a level above their understanding and the educator would not "come down". Given the programme as outlined in 5.1.1.2.8.2 above, it is possible that the sessions were too Western in their approach and hence were inappropriate to the patient population.

One patient related how the doctor who saw her could not hear the foetal heart. He said that he was not concerned. The patient was very distressed. She spoke to a midwife and requested a sonar which was arranged for her. This patient perceived this incident in the light of the shortage of staff in relation to the number of patients. She did not attend the ante-natal classes, but was having her fourth baby at the hospital and was speaking about how the care could be improved. Despite this being her fourth baby at this hospital she had not been aware of the ante-natal classes and felt that they needed to be advertised in a more prominent manner.

5.1.1.2.9. Care expected during labour.

As in Question 6 patients had difficulty describing the care that they expected to be given during labour. Ninety-six patients related care to the need for guidance in breathing and pushing techniques. The need for emotional support is expressed in the use of the words such as "cared for with warmth", "patience", "good heart", "speak kindly" and "prayer". Other comments were "to be well looked after" (64), "they can't stop the pain" (20), and "take care" (23). One seventeen year old stated "never again to have another baby, whether care taken or not." Oakley (1993:61) in discussing what women want states that "the implication is clear: what women want is emotional support."

5.1.1.2.10. Whether midwives were helpful

This question asked whether the midwife did or said anything that was helpful. Again patients could state "yes " or "no", but had difficulty in stating what had actually been said or done. If

- two patients qualified this by saying "with guidance", one said with help and love, one said that the midwife tried a lot, but she didn't understand and the midwife explained it all again after the birth. Reference was also made to being spoken to in her own language. Thirty-two patients found that the midwife was supportive in guiding breathing and pushing. Thirteen patients referred to being told the truth and "right things". Statements from six patients showed evidence that care had been individualised, e.g. being told about the dangers of a high blood pressure and the need for early hospital care in the future and school going mothers were encouraged to complete their schooling.

5.1.1.2.11. Whether midwives were unhelpful

This question probed whether the midwife did or said anything that was unhelpful.
Patients appeared to have difficulty describing actions or words that may have been unhelpful. They also appeared to have difficulty in distinguishing this question from the previous one. Twenty-eight gave an affirmative response, but could not elaborate and 23 gave a negative response.

5.1.1.2.12. More helpful

This question sought to determine whether there was anything that could have been done to be more helpful.
Once again, patients appeared to have difficulty in answering this question and most tend to relate aspects to things they themselves should have done. Some of the comments made were: to attend the classes for pregnant mothers (29) and the need to "follow the rules" (12). One patient stated that what is going to happen in labour should be taught during pregnancy - "the less surprise the better". She felt that the classes should be stressed and the content covered in them should be made known. Five patients made reference to the night staff. Of these, two stated that the night staff had refused to help and three felt that the number of staff needed to be increased. Five patients made reference to the standards. They felt that what they had experienced was satisfactory and that this level should be maintained. Oakley (1993:247) states that studies of womens' satisfaction with maternity services have revealed dissatisfaction with

lack of information, poor communication, long waiting times and absence of continuity of care being the most frequent complaints. These factors are consistent with the complaints of the women in the community focus groups (vide 5.1.2.5 p 156). The fact that these factors did not feature in this part of the study may be explained in terms of the type of service which these women had experienced prior to the hospitals being opened to all races.

5.1.1.2.13. Aspects of care given during labour.

Patients were asked to respond to various concepts that may influence the labour process and whether these concepts had been considered during their labours. Table 5.5 reflects their opinions.

Table 5.5. Patients opinions regarding aspects of care during labour (N=250)

Aspect of care		yes	%	no	%
13.1	pain relief	8	3,2	242	96,8
13.2	support and comfort from midwife	246	98,4	4	1,6
13.3	support and comfort from companion	50	20,0	200	80,0
13.4	respect for your culture	* 243	97,2	2	0,8
13.5	respect for your labour requests	237	94,8	13	5,2
13.6	respect for you as a person	* 245	98,0	3	1,2
13.7	information about labour progress	244	97,6	5	2,0

* one patient responded that as a Xhosa she needed to follow her culture.

It is disturbing to note that 242 patients stated that they had not been given pain relief. When this finding was analysed against age, the following was found:

5 out of 6 were in the 15-17 year age group;

49 out of 50 were in the 18-21 year age group;

45 out of 46 were in the 22-24 year age group;

51 out of 56 were in the 25-27 year age group and

42 out of 43 were in the 28-31 year age group.

It would appear that the younger women are expected to be able to cope with pain. However, this finding may also be explained in the light of some of the statements made by women in the focus groups. One woman described how she was humiliated when she expressed her pain during labour (vide 5.1.2.5 p 156). In addition to age, parity was analysed against this concept. It was found that 85 of the 88 primiparas reported not getting pain relief and 84 second time mothers. Given that only 29 (32,9%) primiparas attended antenatal classes, it is important that midwives inform women antenatally of their options because measures such as pain relief do not appear to be offered by the midwives in labour ward.

However, this finding is not consistent with the records - both in the patient files and the drug registers. It implies that patients are being given medication without their being fully informed. One questions whether they are given medication without their consent.

None the less the women's responses cannot be disregarded especially when 200 women stated that they did not have the support from a companion during labour. 160 of these women were in the 15-31 year age group and 45 of these were under 21 years. When one is in pain, alone and in a strange environment and being cared for by strangers the labour experience cannot be pleasant. Age and the lack of life experiences will not provide these women with coping skills. Furthermore, 69 of these women were primiparas. This means that they did not have previous labour experiences from which to draw.

The lack of a partner or own support person during labour has been managed by other busy obstetric units by the use of voluntary workers who provide companionship to the labouring woman. This woman is known as a "doula" and her function is to provide mothering and caring acts to the labouring woman. For example, wiping her face, holding her hand and rubbing her back. The use of a support person in labour is consistent with the active management of labour described by O'Driscoll et al in 1969 (Hofmeyr and Nikodem 1996). Hofmeyr, Nikodem, Wolman, Chalmers and Kramer (1991) conducted a study in a community hospital in Johannesburg, in which they assessed the effects of companionship on the progress and

perceptions of labour and breastfeeding. Women who were nulliparous and who had no supportive companion during labour were recruited into the study. The sample size consisted of 189 women, of which 92 were randomly allocated to the support group and 97 to the control group. The support group were accompanied by three women selected from the community. These women were selected from twenty applicants, after they had been interviewed by two of the researchers and after role-playing their ability to express empathy. In providing companionship during labour these women were requested to provide the labouring woman with comfort, reassurance and praise. Their results did not show significant effects on the clinical progress of labour, but there was a marked effect on the way the respondents reported experiencing labour. Various measures of labour pain were significantly reduced in the support group, analgesia was needed significantly later after entry into the study and the supported women reported far more frequently feeling that they themselves had coped well during labour. In relation to breastfeeding, the women in the support group experienced significantly greater breastfeeding success. They reported fewer feeding problems and were more likely to have adopted a flexible feeding approach to feeding times. Hofmeyr and Nikodem (1996:98) state that "... we need to ensure that we place appropriate emphasis on the supportive aspects of our work, both in our day-to-day care of women during childbirth and in the training of students."

5.1.1.2.14. Care that patients expected to be given after the birth.

The majority of the patients 89,2% (223) responded to this question by stating "to look after my child". Five expected, "both of us", to be well looked after. Two patients would have liked a few days in hospital. Again the need for support from the night staff was requested. One patient who had had her fourth baby at the hospital felt that her experience had been recognised, but that when she needed help she could ask for it. It is interesting to note that 223 women did not relate care to themselves, rather they expected to have care given to their babies. Once again, patients had difficulty answering this question, in that they could not describe their expectations of care. Oakley (1993:45) states that in most instances patients do not have opportunity to choose the care they want. She goes on to say that choice requires

alternatives, information and imagination. "You cannot choose something if you do not know it exists and cannot imagine it existing."

5.1.1.2.15 Method of feeding.

Just over half 58% (145) of the patients planned to breast feed their babies. Sixteen planned to bottle feed and eighty-six to breast and bottle feed. (vide 5.4.1.1.4.4 p 233) Three patients were still unsure. When one considers that the Scope of Practice of the registered midwife states that she should promote breast-feeding then the number of patients who plan to breast feed suggest that midwives are not actively promoting breast feeding.

5.1.1.2.16. Post-natal health information.

Patients were asked whether they had received health information regarding post-natal issues. The responses to this are shown in Table 5.6.

One patient refused to answer from 16.5-16.17 and one would not answer this question. One patient who responded "no" to most of this question stated that she had been given this information during her previous admissions to the unit. It is disturbing to find that 83,2% responded to no information on vaginal discharge; 84,4% to no information on burning on micturition; 90,8% to no information on constipation and 88% to no information on pain in the legs. These are all actual or potential problems in the puerperium. It is also disturbing to note that 94,8% and 95,2% respectively stated that they had not had information regarding danger signs for herself and her baby. These findings are significant at $p > 0.5$ level. When danger signs for self were analysed against parity 81 of 88 (92%) said that they had not received this information and 83 of 88 (94,3%) said that they had not received information regarding danger signs in the baby. For second time mothers the negative response rate was 84 of 90 (93,3%) and 83 of 90 (92,2%) respectively for self and baby's danger signs. When the t-test was applied, these findings were all found to be significant at the $p > 0.5$ level. Regarding the latter one patient who responded negatively to this question said that she had heard it being given when the patients were discharged. When one considers that patients are discharged 8-72

hours after delivery, then information for self-care is essential. However, one questions the value of this information because when so much information is given at once, it is not possible for these mothers to comprehend and remember such a volume of information. This finding is consistent with the views expressed by both the final year students, where they stated that the giving of information was inadequate (vide 5.3.1.2.17 p 216) and with the views expressed by the graduands that health promotion was not always appropriate (vide 5.4.1.1.4.4 p 233).

Table 5.6. Health information given regarding post-natal concepts (N=250)

Concept		yes	%	no	%
16.1	Breast care	245	98,0	3	1,2
16.2	Vaginal discharge	40	16,0	208	83,2
16.3	Hygiene needs	241	96,4	7	2,8
16.4	Sexual needs	241	96,4	7	2,8
16.5	Burning on micturition	36	14,4	211	84,4
16.6	Bowels \ constipation	20	8,0	227	90,8
16.7	Pain in legs	27	10,8	220	88,0
16.8	Breastfeeding	233	93,2	14	5,6
16.9	Care of bottles \bottle feeding	245	98,0	2	0,8
16.10	Baby bathing	246	98,4	1	0,4
16.11	Nappies \ stools	245	98,0	2	0,8
16.12	Immunization	243	97,2	4	1,6
16.13	Registration of the birth	246	98,4	1	0,4
16.14	Danger signs - self	10	4,0	237	94,8
16.15	Danger signs - baby	9	3,6	238	95,2
16.16	Well baby clinics	246	98,4	1	0,4
16.17	Post natal support groups	246	98,4	1	0,4

5.1.1.2.17 Expectations regarding care.

Questions 17.1-17.3 asked whether patients felt that their expectations regarding care had been

met during pregnancy, labour and the puerperium. The responses to these questions are shown in Table 5.7.

Table 5.7. Patients perceptions of care met during pregnancy, labour and the puerperium (N=250)

	Pregnancy	Labour	Puerperium
Completely	243	246	247
Almost completely	2	2	1
Hardly at all	1	0	1
Not at all	4	2	1
	250	250	250

The high response to care having been met "completely" is explained in terms of the patients interpretation of the care given. If the task was completed successfully then the expectation is considered to be complete, e.g. if the placenta is delivered without any problems then care is said to be complete. Patients appear to view care in a functional or task manner, rather than holistically. It may also be argued that having interviewed the women post-natally, they are experiencing a halo effect following a safe delivery. The fact that privacy is provided would also be a significant factor for these women, especially for those who have delivered in some of the smaller rural hospitals and clinics. In these settings space is limited and there is overcrowding, making privacy almost impossible. Oakley (1993:35) quotes a study in which a satisfaction rate of 95% was reported of an antenatal clinic. She goes to state (1993:36) that "what patients expect has been shown significantly to affect satisfaction levels."

5.1.1.2.18 Place preferred for birth if patients had the choice.

Figure 5.4 shows responses to the preferred place of birth if patients had the choice.

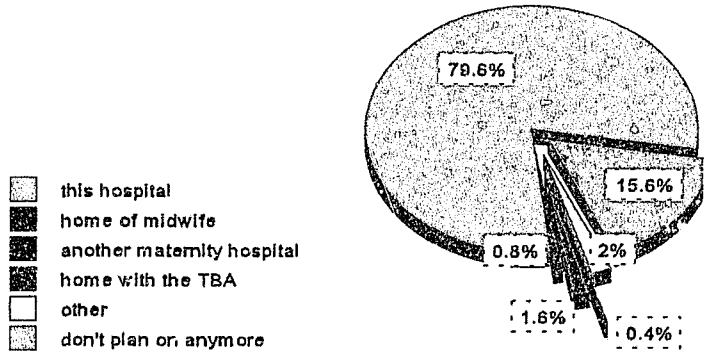


Figure 5.4 Place preferred for birth

Given patients reasons for choosing to come to this hospital it is not really surprising to find that 79.6% (199) would choose this hospital for future deliveries. It was surprising to find that only two would choose to deliver at home with a midwife and only one would choose to deliver at home with a traditional birth attendant. This may be explained in terms of the patients becoming more urbanised in their approach to health care, where Western medicine has socialized women into believing that the best care is provided in high care institutions. This means that in adopting the primary health care approach to health care both patients and staff will need to be resocialized in their understanding of the provision of care. Oakley (1993:63) quotes a study done in the United Kingdom in the 1970's which assessed the womens' preferences for place of birth, analgesia and induction. With reference to place of birth, 91% who had had a home birth would choose the same again and 83% who had had a hospital birth would choose the same again.

5.1.1.2.18.1 Reason given for preference.

Most patients did not give a reason for their preference. Eight stated because this hospital is so good (and one added "with support") and one that this was the only institution that would allow her a normal vaginal delivery after a Caesarian Section. The same patient stated that she could not afford the cost of a delivery in a private institution. Other reasons cited were the cleanliness of the hospital; its academic status and that the midwives in labour ward were good. These findings may be explained by the unsatisfactory home conditions in which many of the women live.

5.1.1.2.19 Suggestions given to improve care.

Again most patients were unable to make suggestions.

Twenty-five felt that care would be improved if they booked early and a further 15 if they attended the ante-natal classes. Twenty-five patients felt that it was the government's responsibility to improve facilities at all the hospitals, with 18 patients wanting a home visit. Nineteen felt that they could not suggest anything, that the care was good. Sixteen patients felt that the security measures at the hospital should be improved. This response was made in the week of interviewing following on the kidnapping of a six month old baby in the paediatric casualty of the hospital. Fifteen patients felt that there was a need to increase the number of staff, with eight of these respondents making reference to night duty. Two patients requested that they be given letters to their employers stating the patients' need for lighter duties.

5.1.1.2.20 CONCLUSION

In summary it appears that the patients are not empowered in terms of their expectations of care. They expect to be cared for, but could not identify what they wanted in this regard. Caring appears to be viewed at a very low level and to be task-focused. Caring around the birth process appears to be seen as best when it is hospital-based. However, in this respect attention needs to be given to the importance of pain relief and the value of a support person for a labouring woman. Students need to have an understanding of the effects of these factors

not only on the labour outcome, but also on the long term effects of the labour on the mother. This needs consideration when planning for maternity services in a primary health care system. Health information and the structure and promotion of ante-natal classes needs attention. This has implications for the teaching of health promotion to students. Given the short hospital stay after the birth of the baby, patients need to be prepared for this during pregnancy. Students need to be able to understand this in terms of the community profile and in terms of the health structure. Tinkler and Quinney (1998:31) quote Baramadat and Driedger as saying that " understanding and measuring women's satisfaction with maternity care is complex and multifactorial." They state that the nature and quality of information given, choices offered about the type of care and women's relationships with caregivers have been found to affect maternal satisfaction.

5.1.2 FINDINGS RELATING TO ENVIRONMENT - THE COMMUNITY FOCUS GROUPS

In this section of the research, field notes and impressions made on the researcher will be described. The analysis and identification of the categories and sub-categories will be described and finally, the categories and sub-categories will be illustrated through the use of quotes from the focus group discussions. (See Annexure T).

5.1.2.1 Field Notes

5.1.2.1.1 Site A. This group was organised through the help of a community leader working in the Hillbrow Community Partnership in Health Personnel Education project funded by W.K. Kellogg. She is also a key figure in the Women's Forum. The researcher was invited to conduct the group in the afternoon of a public holiday. The venue was the offices of Actstop (a political organisation) in a high rise building in Hillbrow. On arrival at the venue, the researcher found that the women were in a meeting. When her arrival was announced she was invited to join the group. There were seven women and three men present. The chairperson of the group asked the researcher if she minded if they completed their meeting as they were busy with the last item. The researcher did not mind. On completion of the

meeting, the researcher said that she found it interesting that men attended these meetings. She was told that it was important that they were there, so that they knew what the womens' problems were. It was also felt that they may be able to advise the women on certain issues. At the beginning of the group the researcher was asked whether she minded if the men joined the group. Recognising a cultural value, the researcher said that she did not, but asked the men not to give their opinions during the group. She would be happy to listen to their opinions after the formal group. This was because the researcher feared that the men would dominate the group and that she would not obtain the women's opinions. Culturally the women are seen as being subservient to the men. However, the men could not totally withhold their opinions and two did comment occassionally. Two of them left the group during the discussion.

Before commencing the group the researcher introduced herself and explained the purpose of the group. She assured the participants of confidentiality and that they were free to leave the group at any stage should they so wish. During the group there was a fair degree of movement in the room as people left to get popcorn and give each person in the room a portion. Then another left to fetch a large bag of crisps, which was then put onto plates and distributed. One of the women had her two little children with her and they were in and out of the room. The atmosphere was relaxed and the women appeared to be comfortable in answering the questions put to them.

Because English is not their home language, it was often necessary for the researcher to re-phrase or repeat questions. Similarly, it was also necessary to re-word the women's responses in order to ensure the same meaning for both the respondent and the researcher. The woman who had organised the group for the researcher appeared to be respected by the rest of the group. When she spoke she was not interrupted by the others, as sometimes happened when others were speaking. There did not appear to be any antagonism amongst the women. When one had problems in expressing herself others would complete the sentence for her. This was of some concern to the researcher, as she wondered whether others were expressing what the original speaker had meant. However, this concern was eliminated for her when one of the

women said something that the original speaker had not meant and she said "no, its not like that". There were a number of pauses and one or two long pauses in the discussion, but they did not become embarrassing. The researcher interpreted these to mean that the women had not understood the question clearly, or she used them to reflect on what had just been said and in this way dialogue continued. One woman appeared to be more political than the others, in her references to what the government should be doing for them

Impressions made on the researcher: these were the tone of voice which the women used when recounting some of their experiences and the repetition of some of the statements. Good experiences were usually recounted in a normal tone of voice, whilst the unpleasant experiences were told in a quieter, almost sad tone. Riemen (1986:30) writes that "the patients feel this noncaring by nurses so acutely that they can describe not only the situation, but also exactly how they felt during and following the interaction." The need for education and information was clear and again the choice of words was strong - "don't know what it's doing, I want to know what its doing inside my body." The researcher was impressed by the apparent pride that these women have in their community and the needs expressed to uplift the community through education. The women did not appear to be embarrassed to tell a nurse about their experiences with other nurses. In fact, it seemed to be therapeutic for them to be able to express their feelings. The researcher left the venue feeling sad and angry - sad that nurses were thought of in so many negative ways and angry with her colleagues that this was the impression that they portrayed of their profession.

5.1.2.1.2 Site B. This group was organised through the help of a primary health nurse educator who worked at the Alexandra Health Centre. She suggested using one of the satellite clinics on a day and at a time when there was likely to be a number of women there for family planning. She liaised with the charge sister and obtained permission for the researcher to use the venue. The researcher was told to come to the main health centre and to leave her car there. She was then taken by a messenger to the clinic. The messenger showed concern for the researcher, in that he escorted her into the clinic and introduced her to the charge sister. After

the introductions the charge sister called for volunteers from the numerous women waiting to be seen. This took place in a large open area which appeared to serve as the entrance to the clinic, waiting area and reception. There was a constant buzz of the human voice. The charge sister indicated a corner of the room which we could use to talk. This was unsuitable for the purpose of the group and the researcher requested that the group move outside. The women obliged. Although it was the middle of winter, it was almost midday and not unpleasant in the sun. The researcher had not bargained for the noise from the hooting taxis which sped passed the clinic, the noise from a jumbo jet passing overhead and the noise from the children who played in the grounds. In addition, this circle of women created a fair amount of interest and passers-by stopped to have a good look. Eight women joined the group, but one left early in the discussion. The women were friendly and willingly shared their experiences. At times differences of opinion were strong and the researcher envisioned having to intervene in an active manner. Fortunately this did not become necessary. This occurred when the structure of the health service was being criticised by one woman and another stated that it was better to co-operate with the authorities rather than to create difficulties for oneself by going to another clinic. The woman who had criticised the structure of the health care services, appeared to be a returned exile. She made reference to the care she had received before (outside South Africa). She was also adamant that the standards of care should be the same everywhere. This woman tended to dominate the discussion and it was difficult to control the dialogue so that others could be given an opportunity to express their views. This group was more verbal than the first and there were fewer pauses and long pauses.

Impressions made on the researcher: that clear incidences stand out for these women of good and unpleasant experiences. Again the tone of voice with which they are described was evident. The good experiences were described in a normal tone of voice and the less pleasant in a quieter tone. Once again English was a second language for this group of women. Again clarification was necessary. In addition, as they became more vocal about certain aspects so their communication became more emotional and at times it was difficult to get the real meaning of what was said. On the whole, their English language skills were better than those

of the first group. It was also evident that some of the women were aware of inadequate care and were able to compare health services. The need for education and information was clear. The comparison of care given by different race groups was interesting to hear. Nurses are judged for not doing certain tasks, such as taking the woman's blood pressure, but not once has she been judged for a poorly performed skill. The researcher once again left feeling angry and sad for same reasons as she had experienced before. However, this time she felt reinforced about the scope of opportunity that exists to empower women through education and could envision opportunities for students to become involved in this activity, thus opening up a community-based education for the students. In addition, this opportunity opens the door to dialogue. Through dialogue, students have opportunity to hear from the women what they feel and need within the context of their culture. In this way, students would be empowered to impart information in a manner which is culturally acceptable and understandable to the women.

5.1.2.1.3 Site C. This group was organised through a counsellor for a cathedral in the inner city. She suggested that the researcher arrive at the end of the morning service on the Sunday morning. She would then recruit a group of women for the group. At one stage it appeared that she would only be able to encourage four women to join. However, at the commencement of the group there were eleven women. The counsellor thanked them for coming and encouraged them to share their experiences, because by so doing they would not only be helping themselves but also the community. The researcher expressed her thanks, explained the purpose of the group, assured confidentiality and said that they were free to leave the group at any stage they may wish. At this point one woman said that she would prefer to leave and to give the subject some thought and write it down for the researcher, as she was afraid that she would not express herself correctly in the group and then would later regret what she had said. The researcher thanked her for her willingness to participate and said that she understood how she felt. The counsellor left with this woman. The service had finished at 11:00 and it was now something to 12:00. During the group women joined and left, so that at one stage there were thirteen women. At the end of the group there were ten. The group was held in a

room upstairs from the cathedral. It appears to serve as a multi-purpose room and tea was served here after the service. Although the group was seated at the back of the room, the noise from the kitchen was disconcerting for the researcher and at one stage some of the participants had difficulty hearing. This improved when the group moved closer together. The ages of this group were probably of a wider range than in the previous two groups and two of the more mature women appeared to dominate the session. However, their presence did not stop the younger women from joining in the discussion. When the older women spoke respect for them was evident, in that they were not interrupted. The movement of women in and out of the group meant that only four women really participated and two made smaller contributions. Two women had never been to a clinic or a hospital and they left the group at different stages.

Despite the reluctance of the women to form this group, there was no difficulty in getting them to talk and to share their experiences. There were a number of pauses and two long pauses in the discussion but they were not difficult silences. As in the previous two groups political views surfaced.

Impressions made on the researcher: the researcher felt that this group was not as successful as the previous two due to a time constraint. Given the time at which the group started, the researcher was conscious of the women watching the time. This was evidenced by them looking at their watches every now and then. The movement of women into and out of the group was also disturbing to the researcher, but did not appear to worry the women. The counsellor returned to the group towards the end. She had spent time with the woman who had left. After the group she told the researcher that this woman had recently had a 91 year old mother in hospital. She had been upset when visiting her mother to find that there was no clean bed linen, that she had been given a wet towel to dry herself and that she had not been helped with her meals. The counsellor had talked the experience through with her. The researcher commented to the counsellor that this was her third group and she was interested to note that in none of the groups had the women mentioned rape, abortion and AIDS as health problems of women. The counsellor said that these issues are very much denied by the

women. She shared with the researcher that when she was approaching women to join the group, one had said "we don't want another AIDS counselling session." Once again the researcher was saddened to hear the women's perceptions and experiences of nurses. As in the previous two groups the depth of feeling that was expressed through tone of voice and speed of talking was clearly evident. As in the previous two groups the researcher was struck by the fact that when asked to describe caring or noncaring experiences the women consistently described noncaring situations first. Use of English was again poor and again the expressions used were not always clear as they became emotive about an aspect. Clarification was necessary and was successful in ensuring effective communication. Driving home the researcher was struck with what wonderful women the focus groups had given her the priviledge of meeting.

5.1.2.1.4 Site D. This group was organised with the help of a woman who is active in one of the churches. She belongs to one of the women's groups, but also assists with lay ministry. Through the latter she has developed good relationships with many of the women who attend the church for a Sunday afternoon service. The researcher met with her one Sunday afternoon to meet some of the women and ask them to participate in a research group. They were willing and it was agreed that the researcher would meet them the following Sunday afternoon. This arrangement was kept and eight women formed the group with three joining towards the end. As this was a winter afternoon with a mild wind blowing, the group was conducted in the church hall. The women were mainly domestic workers and were older women, in comparison to the previous groups. Their families appeared to be complete. These women were all well dressed, some in a uniform which identified them as belonging to a lay women's religious group. They were friendly, polite and very willing to help. This group was the most difficult to get to talk. This was not because of their language skills which were fairly good. There were many pauses which bordered on becoming embarrassing. Answers and descriptions of experiences were brief.

Impressions made on the researcher: It was something of a surprise to the researcher to hear

nurses being spoken of in a positive manner in comparison with the previous groups. These women also did not speak as freely as the women in the previous groups had. The researcher had the impression that given these womens' religious beliefs, they did not wish to criticise too harshly. The geographical position of the suburb may also have contributed to these women's experiences, as the facilities which they mentioned as having attended for health care were the same ones which had been favourably reported by women in the previous groups. It was also evident that time had dulled their memories with regard to some of their negative experiences. This became clear when one of the woman recalled how she had been treated when she had her baby. English language skills were slightly better in this group of women and this may be a result of the nature of their occupations, where they communicate more frequently in English with their employers. Living in a more affluent part of the city also seemed to mean that these women do not attend the health services as frequently as the women in the previous groups. This may either be due to a better health status or to them being cared for by the employing family's practitioner. However, the women appeared to take responsibility for their own health needs. This aspect was not probed. The researcher felt disappointed after this group as it had been very hard to get these women to understand the meaning of some of the questions. She felt that this was a religious group of women, who really wanted to please. After the group, when the researcher was giving them each a small gift for participating in the group, one of the women said "You must come again and teach us."

5.1.2.2 Questions which were put to each focus group

The focus group interviews were semi-structured in that a common set of questions were put to each group of women. These were:

- Have all of you had a reason to visit a hospital or clinic for yourselves?
- What type of health care service did you visit ? Was it a hospital or a clinic? Who provided care for you at these visits?
- How did you experience the care given to you by the nurses? What did she say or do that was helpful? What did she say or do that was not helpful? As a woman was there anything that you would have liked to have been done for you? Do you think that nurses

can play a role in improving women's health?

- I'm not sure how much you know about a nurse and midwife's training. But, what do you think that it should include?
- What do you think are the main causes of women's illnesses? What are the most common illnesses you think women suffer from? How do you think that women can be helped to take responsibility for their own health?

At the end of each group the researcher reflected on the women's responses to the questions posed and in this way obtained member checking.

5.1.2.3 Analysis and findings of the group interviews

The analysis of the group interviews was done using Tesch's eight steps as a guide (vide 4.5 p 119). In applying these steps, the following processes were performed on the raw data:

- all the transcriptions were read through twice to get a sense of the whole;
- each group interview was then taken separately and analysed for meaning. This required analysing sentence by sentence and putting it together to get the respondent's meaning. Significant words and phrases were underlined and their meaning was interpreted. Using a large sheet of paper and two columns - one for meaning and the other for the word or phrase, each transcript was analysed for meaning and interpreted.
- similar topics were clustered, e.g. nurses responses to patient needs and enquiries were clustered and named nurses behaviours / attitudes, phrases which described humiliation and belittling were clustered together and named feelings.
- the text was then analysed against the topic and coded accordingly;
- the topics were then analysed for similarity and reduced into sub-categories, e.g. time was mentioned in relation to starting times, length of time kept waiting and time that nurses took for tea. Thus "time" was a topic. Another topic related to the nurses failure to recognise those in need. Thus a sub-category "lack of concern" developed.
- sub-categories were then analysed for similarity and grouped together into categories, e.g. the sub-categories of the image of the nurse and the women's expectations of the

nurse developed into a category describing the nurse.

- data belonging to each category was then assembled;
- existing data was recoded where necessary. The coding process was again refined during the writing-up process.

A massive amount of data had been collected from the focus group interviews. The coding process was an exacting and time consuming process. It required constant comparison of the data in order not to loose the richness of the descriptions and the comprehensiveness of the data. This meant that collapsing the data into categories and sub-categories was a difficult process.In addition, it demanded that the researcher keep reflecting on the true meaning of what was said. This bracketing was necessary in order that the researcher's own feelings and ideas did not influence the meaning of the experiences described. Literature checks were done to substantiate the data.

5.1.2.4 Categories and sub-categories

Thus from the focus groups the following categories and sub-categories emerged:

		No. of Informants	No. of occurrences
A. Community women			
a)	patient compliance	2	4
b)	need for information and knowledge	13	32
c)	lack of concern for the patient	14	39
d)	women's feelings and responses to care	27	34
e)	disempowerment	4	4
B. Environment			
a)	psycho-social-political factors	11	17
b)	need for a safe environment	4	4

c)	community participation	6	10
C. Health			
a)	health services	11	19
b)	patient rights	11	14
c)	perceptions of health problems	18	26
D. Nurse			
a)	image of the nurse	19	51
b)	expectations of the nurse and other health professionals.	12	30

The findings will be discussed under the four categories, viz. community women, environment, health and nurse. Given the standard of English spoken clarifying words will be given in brackets or explanations will be given of what was meant.

5.1.2.5 A. COMMUNITY WOMEN

a) compliance

Women described the importance that compliance appears to play in the care which they receive. If the nurse perceived that the woman was not complying with the prescribed treatment, then the women were criticised by the nurse for their non-compliance. Nurses were described as being noncaring by giving more Panados and walking away from the woman. Another woman described how when the nurse saw her she asked in harsh words and tones "What's the matter?" The nurse went on to question the woman about her hypertension. She described how the nurse took her blood pressure in a rough manner and when it was found to be low, the nurse said "alright its low" and she was given Panados. Thus it would appear that compliance appears to be a significant factor for the women in maintaining the nurse-patient relationship. This was evidenced in the following statement:

If you want to go hand in hand with people (meaning the nurse), you must listen to what they tell you.

b) the need for information and knowledge

The women expressed a need for information and knowledge. This need referred to the lack of explanation for treatment given and the lack of understanding of the action of contraceptives. One woman who had used Depo-Provera described how she needed to know what it was doing to her body. She did not know whether it was going to prevent pregnancy or whether it was going to prevent her from having sexual feelings or whether it interfered with breast-feeding. She felt that she was just given the injection without any explanations.

They must explain what this is going to do in my body.
... Not just give me the injection.

Women were able to clearly compare and contrast incidences when they had or had not been given explanations and information. One woman said:

She taught me how to wash the baby.

This woman went on to describe how she was "*shocked to see such a nice lady.*" This nurse had taught her how to remove the baby from the breast when breast-feeding, how to change the baby's nappy and had discussed contraception with her. The latter had included advice on when she could resume sexual intercourse. She described this nurse as "*such a kind lady.*"

This experience was in contrast to another woman's experience when she'd taken a crying child to the clinic. She said:

When they're finished (examining the baby), they won't tell you what's wrong with the baby. They only give you Panados.

The need for information and knowledge was extended to a request for workshops and lectures and for sex education for teenagers.

There must be sex education here at the clinic. There are young kids from school. They come here for family planning.

This woman felt that the teenagers were not being taught or being given advice about what was best to use, in terms of contraceptives. She said that the teenagers had only to request what they wanted to use. She felt that they should have been given some explanation and advice as to what was best for them. Instead

They don't do that. They just inject them or give them tablets.

The women are conscious of their lack of knowledge and of the nurses' ability to teach and so to help them. An elderly woman described how she knew that the nurse had to study and work hard to obtain her certificate. She felt that the nurse was now in a position to be able to help them

They've worked hard to be where they are, but now they must .... help us.

c) lack of concern for the patient

The nurses' lack of concern for the patient was described in terms of time factors, denial of pain, failure to pay attention to those in need and the priority given to their own needs. The concept of time was raised in relation to time of starting the clinic, closing the clinic and length of time spent waiting to be attended and seen. It appears that the time factor is related to the nurses putting their needs first and to the lack of notice given to those needing attention more urgently.

One woman described the length of time spent waiting at the clinic even if one arrived early. She said that she arrived at eight o'clock and only left at two o'clock. During this time she perceived the nurses as noncaring.

They just leave people lying all over. They don't even care for the sick people. You can faint there, they don't mind. .... nurses they don't care.

She felt that it was often left to the other clients waiting to be seen to help a person who was urgently in need of help. This situation was aggravated by the fact that nurses would take no notice of this situation - *they just look at you and pass (by).*

During the time that she spent waiting she observed the amount of time that nurses spent at tea and at lunch. They started to go to tea at ten o'clock and they all went at the same time. She stated that she could not understand why they did not stagger their tea times. Tea time no sooner seemed to be over when they all went for lunch. During these times the clients were just left to wait.

> *When they are going for tea time they are taking one hour. For tea time.*

Frustration was also expressed in relation to the starting times at the clinics. This was expressed by one woman,

> *Their starting time is very bad. We are sitting here waiting for an hour. They say they are open at eight o'clock. We arrive here before eight o'clock.*

To this another added:

> *I don't know what exactly time they open, because at nine - that's when they open.*

There was equal frustration at the closing times. One woman described how she was made to wait until the Monday for help because the clinic closed at twelve on Fridays. Another described being at the clinic at seven o'clock and left at one o'clock without being seen because the staff said that they had to attend a meeting.

> *We waited there until five past one. They told us they've got a meeting.... We just go home.*

The lack of concern in relation to time and the patient's perception of pain was vividly recalled

by one woman as follows:

> *Some nurses don't care. Even if you are complaining you are in pain, they sit and make you wait, instead of taking you straight in. Instead they shout at you and tell you we have a queue. Can't you see there is a queue? Who do you think you are to go straight in? There are some nurses they just scream .... without any consideration. They can see that this patient is in pain.*

This same woman was able to recall a positive experience which she personally had had, when her pain was noticed timeously. She recalled it as follows:

> *When I got there, I had fibroids, I was bleeding a lot. I lost a lot of blood. When I got there, I was dizzy. I couldn't walk properly. I was dizzy and I was faint. The nurse came straight to me - leave all the patients and she just came to me. She said ' come get on the bed.' I was so grateful.*

Women also expressed anger at the manner in which their perceptions of pain or discomforture appeared to be questioned by the nurses. One woman described her experience of this when she was in labour and she felt that she was treated as a child.

> *Sometimes they ask - how old are you? Don't react like a child.*

Another described taking an elderly friend who was coughing and short of breath to hospital. She described the long wait, being sent from one area to another with the elderly woman, and how the elderly woman's complaint was questioned.

> *They don't care. ..... when I said she's got a short breath (is short of breath), they said she don't look like somebody who's got a short breath (who is short of breath).*

Lack of concern for patients in distress was described by one woman as only getting attention when the situation became serious. She had witnessed a situation where a man had arrived early in the day, complaining of feeling tired. After a period of two hours, he fainted and the nurses then called for an ambulance. Another recalled the lack of concern she had experienced

when she was in labour. She stated that:

When we give birth, the nurses are very rude.

She described being left alone and in pain until a male nurse took notice of her. She felt that the nurses only took notice when they realised that she had a breech presentation and that she was close to delivery. She described the rush to prepare her for theatre for a Caesarian Section. She described her experience as being

... terrible from the start, from going into the hospital.

She said that the nurses said that she was complaining of pain to get attention and that they did not care that she was genuinely in pain.

This lack of concern for urgency of attention is aggravated by the nurses giving priority to their own needs. Nurses were perceived to have greater awareness of their tea times than client needs. In addition they are perceived to have lengthy tea breaks -

.... they go for many minutes or hours ...

Attention to own needs was also related to the clinic's starting time. Despite the starting time being given as eight o'clock, the nurses had tea before they commenced their work.

These statements suggest that the nurses and patients have different agendas in relation to health care delivery. This is evident in the discussion relating to routines of opening times and tea times.

d) women's responses to health care

The women described their feelings and responses to the care they received. Their responses

describe feelings relating to self-worth, e.g. humiliation, placating and belittling. Some expressed dissatisfaction with treatment and this was sometimes associated with feelings of anger or despair. Others felt that they would rather avoid using the health services.

Responses which revealed an effect on their self-worth are evidenced in the following statements:

humiliation

You are rejected.
Then they laugh, laugh at them.
So you end up being foolish.
You are not paying.
You feel like the dustbin.

belittling

This is illustrated in the following comments:
What do you think you are to go straight in?
Don't react like a child.
Like you are stupid, you don't know what you are doing.
We don't want them to take us like classroom, like kids ...

placating

They only give you Panados.

In addition to the above feelings, there also appeared to be a feeling of being punished by the nurses. This feeling was expressed by two women as follows:

> *We are scared as if they are going to punish you, shout,*
>
> *... She came back after the doctor (had gone) and gave me hell.*

dissatisfaction expressed

The women are not satisfied with the treatment which they receive. This was expressed by one woman who had experienced care differently elsewhere. She described how she had been checked at every family planning visit. She had never been checked at this clinic. She outlined the questions which she felt that the nurse should have been asking in her assessment. Another woman felt that nurses should see their work as a *'challenge'*.

> *They musn't be like this.... It must be like a challenge. Because it is a challenge.*

patient interventions

Another response to the treatment experienced was for the woman or patient to intervene herself and assist another patient. This was described in both hospital and clinic situations. One woman described how her elderly mother assisted the patient in the bed next to hers with her meals. This was despite the fact that her mother was supposed to be at bed rest and this caused her some anxiety that she would be found out of bed.

> *My mother was admitted here, in Hillbrow. And next to her was this lady, she had a hip replacement or something and she couldn't feed herself. She was lying in bed, it was something to do with her back. She couldn't feed herself. My mother told the nurses - they just ignored her. And one time I went there she was busy feeding the other patient. She had to feed her. They didn't care and sometimes she used to pray they didn't see her because she wasn't supposed to get out of bed.*

In this description the patient's conflict between non-compliance of her own treatment and care for another human being was well illustrated.

In clinic settings patients were described as being helpful with directions. One woman described how as a result of her hospital admission she had learnt her way around and so she frequently gave directions and assistance to other out-patients.

e) disempowerment

The women lack empowerment. This was evidenced in their inability to ask for information or explanations and in their apparent subservience at the clinics - waiting long hours and feeling that there is nothing that they can do about it and in their acceptance of the manner in which they are spoken to by the nurses. Disempowerment is reflected in the following statement:

We're not happy at all, but ... what can we do?

However, one elderly woman had challenged a nurse about her attitude and caring behaviour. Her knowledge of the socialization of the student in her education was clearly evident. This woman had family members who were nurses and in challenging the nurse she reminded her of Nightingale and her pledge of service.

In describing this category feelings of urgency, determination, anger and sadness were evident. The positive relationships were described in a quiet tone. In relating some of the experiences women appeared to relate them in the tone of voice used by the nurse.

5.1.2.6. B. ENVIRONMENT

The environment was described in psycho-social-political terms, which incorporates a trusting environment and in terms of the need for community involvement and participation.

a) psycho-social-political environment

This sub-category described care in psychological, social and political terms.

The psychological was related to respect for age. Respect for age is a strong cultural value and when elderly women felt that nurses younger than them no longer treated them with respect they felt that this value had been lost. One elderly woman stated that a nurse had said:

Oh! We haven't got time for old people.

Respect for age did not only relate to the manner in which they were spoken, but also to information given to them. One elderly woman appeared embarrassed when she described how it was alright to talk to young people about condoms, *but when you're older ...* Culturally information relating to sex must be approached carefully. One does not simply give this information.

The social environment was described in terms of social status. Nurses were perceived to favour clients from the higher social classes. Women described how if a woman arrived in a BMW motor car she would be seen immediately and wouldn't have to wait. They felt that such a woman was treated with respect. Social status also related to residential area. Many of the nurses still live in formal black settlements outside of Johannesburg, but work in hospitals and clinics in the city. Most of the women who they treat, however, live in the city. One woman described how the nurse had shouted at her and asked why she was sick when she lived in the flats. (Flats refers to the city.) She went on to say:

> *Because they are from the location, they wonder why I am staying here.*

The political environment was described in terms of care given and received by different racial groups. One woman described the care she had received after the birth of her baby.

> *After I deliver(ed) my baby, there was another lady, she was a white lady, she was a nurse. I told her that I have a problem. She was so good to me. She taught me to wash my baby. She was such a kind lady. I prefer white ladies ... they are good.*

An elderly woman stated that she experienced care from both black and white nurses. She went on to say:

> *We must face a fact. The white ones ... we did get tender care, but now this young black ... no tender care to you.*

There was agreement amongst the women that black people don't care for each other. One

said:

No we don't love each other.

The psycho-social-political environment perceived by the patient is a complex and difficult one, but certainly one that needs to be addressed in the education of the nurse.

b) need for a safe environment.

The women do not perceive the health care environment to be safe in terms of trust Nurses were perceived as being moralistic and lacking in confidentiality. This resulted in the women feeling guilty and embarrassed. One woman described how she was made to *'feel bad'* and that she'd done something wrong when she requested a Pap smear. She stated that the nurses had shouted at her and asked her *'Why do you want it?'* In relation to Pap smears, another woman stated:

You get shy to go there and ask for those things.

Another woman described how her friend had confided in a nurse. The nurse called others to come and listen. Her friend had felt hurt because she'd gone for help and instead she now felt that they would all be talking about her.

It would appear from these experiences that women do not feel safe in approaching nurses for their health needs. The importance of trusting inter-personal relationships needs to be instilled in the student and the skills to do this need to be taught.

c) community participation

Women expressed the opinion that the community needed to be involved and to participate in the provision of health care. Women felt that it was important that the community should be trained to work with nurses. In addition, it was felt that if they worked with the nurses, the

nurses would gain a better understanding of the problems of the area. This need was further extended to being able to render help in an emergency. Time delays in getting ambulances and in getting the injured to hospital is seen as a major problem in many areas and it was felt that if community workers were available to render emergency care, many lives could be saved. One women also felt that there was a need to have community midwives. This appeared to refer to traditional practice because she said,

> *Most of them are not midwives. They are not trained to be midwives. But they are very excellent midwives.*

These statements support the need for community-based education.

This sub-category of statements was generally expressed in a quiet tone. The more political statements carried a trace of sadness and if the speaker was challenged, a tone of defiance was evident.

5.1.2.7 C. HEALTH

This category was characterised by descriptions which referred to the health services, patients rights and perceptions of health problems.

a) health services

The health services were spoken of in terms of problems in its structure, its uses and functions and the consistency of the services.

problems in the structure

Women spoke of the lack of community nurses, the poor ambulance service and the zoning of areas as being problematic. One woman described how valuable a community midwifery service had been to her. She had been visited everyday at home for ten days and if there was a problem she was taken by car to the clinic. She felt that she was being guided in her health needs. The delays in the getting an ambulance and the poor quality of the service was described.

People are having babies in the flats. Because the ambulances, they just take hours (to come.)

This aspect supports the need described in the sub-category community participation for the community to be trained in emergency care. Zoning of services appears to cause resentment for some of the women. The women would prefer to be able to attend the clinic or hospital of their choice. In addition, they feel that if they are visiting or shopping in an area away from their homes that they should be able to use the nearest health facility.

uses and functions of the services

Women appeared to use the health care services mainly for curative reasons. They stated that they went there if they had flu, needed medication or if they felt that something was wrong. The most commonly cited preventive reason was family planning. They appeared to be reluctant to use the services for other preventive measures such as Pap screening, (vide 5.1.2.6 need for a safe environment p 166). Of a total of 33 women who participated in the groups, four stated that they had never used a health care service. Two of the four practised self-care and self-medication. One of the four stated that she went to a private doctor.

In a number of instances the experiences which were recalled in relation to perceptions of care and use of the services were related to pregnancy and labour.

Thus it would seem that women perceive the health services as having a curative function. Self-medication and self-care may also be a coping mechanism for women. This may also be explained in terms of the role of women as care-givers.

When I feel sick, got the flu, a cold, I just take Panados

consistency of the services

The services are not perceived as providing a standard service throughout. Women described how they are given a *'thorough check-up'* at certain clinics, while at others they were told on the Friday to come back on the Monday. When recalling experiences of care received, the

women distinguished between the different hospitals. It was notable to the researcher that this was consistent, i.e. those which were described unfavourably were always the same hospitals and those which were described favourably were always the same.

b) patients rights

In describing their rights women referred to the following:

right to participate in care;

right to be respected as a human being;

right to be spoken to in their own language, and

a right to expect a consistency in the services.

Despite them appearing to be a disempowered group, the women demonstrated an awareness of their rights.

We would like to have respect.

c) perceptions of health problems

The women perceived their health problems to be mostly the sexually transmitted diseases, including HIV and Aids; cancers of the cervix and breast, hypertension, asthma, menstrual problems, diabetes, alcoholism and problems related to their occupation as domestic workers. They perceived the cause of their problems to be related to the use of contraceptives, stress and worry, family disturbances and hormonal factors.

In none of the groups did the women spontaneously mention abortion and rape as health problems and yet there is a high incidence of both in the South African society. The counsellor at the Cathedral in the inner city felt that women are in denial about the extent of these problems.

There is clearly a need for education, as many of the women have little information and at times understanding of the health problems which they identify as being important in the women in their communities is incomplete. This can be seen in the following statement:

And we don't know what are the symptoms of AIDS. What is (are) the differences of (between) AIDS and TB? We don't know those things.

In this category, feelings of frustration and resignation were evident. Their rights were spoken of in a strong voice which gave an impression of determination and willpower. The sub-category on perceived health problems required prompting from the researcher and the impression of uncertainty was evident in the hesitancy with which responses were given

5.1.2.8 D. NURSE

References to the nurse and nursing fell into three sub- categories, viz. the image of the nurse, patients' expectations of the nurse and references to other health professionals.

a) image of the nurse

The nurse was described in both positive and negative terms and there was frequent mention made that nurses are not all alike i.e. that both caring and noncaring behaviours had been experienced - *'they goes up like this (indicating a slope) - .... sometimes you meet another (a) good one, sometimes you meet the bad ones.'* There were very few positive responses regarding the image of the nurse in comparison with negative responses. There was reference to her superior attitudes and acknowledgement of her educational status. Inter-personal relationships were described and the nurses' perceived lack of interest.

positive caring experiences

Features which characterised positive experiences for one elderly woman were communication, tone of voice, touch, enquiry about health and being physically assessed. For a younger woman who was describing a positive experience post-Caesarian Section, the significant features of care were communication, tone of voice, touch and being helped physically.

> *You know he greet you nicely when you get in.*
> *And then he ask you what's wrong?*
>
> *The way they touch your child, you know.*
>
> *You see the way a person is helping you to bath the child.*

negative experiences

Features which characterised negative experiences were communication, which was described as *'rude'*, lack of help or not giving instructions and not reacting to persons in need of help.

attitudes

It appears that the attitudes of the nurses influenced the way in which the meeting was perceived. An attitude which was frequently described was that of superiority. One woman giggled as she mimiced and said:

> *Mmmm, the way they walk. You can see the way they walk with that (pointing to her shoulders and referring to epaulettes).*

Another non-verbal communication that was construed as superiority was *'the way they look at you. They just look at you and pass (by)'*

inter-personal relationships

Poor inter-personal relationships were described. One woman stated that her relationship with nurses was like *'working for a boss'*. Another described the argument that ensued between her brother and the nurses when she was in labour. Her brother confronted the nurse for the manner in which she had spoken to the woman and reminded her that she was employed in the hospital to care for the patients.

nurses lack of interest

The poor inter-personal relationships appear to be aggravated by a perceived lack of interest on the part of the nurses. This was evidenced in statements such as *'they're tired of us'* and *'they take no notice'*. One woman described how her elderly mother, an asthmatic, had been taught how to use the pump. The woman was shown once and when she hadn't mastered the technique she was told that *'you'll have to teach yourself.'*

The nurses' lack of interest is perceived in relation to their occupation as a means to a salary.

One woman said *'...most of them are working for salaries. It is not a challenge. They don't care what is happening to us.'* and another said *'they're in a career.'*

It would appear from the above statements that verbal and non-verbal communication and touch influence the perceptions of the image of the nurse. Woodward (1997:1001) quotes Fielding and Llewelyn who have written that " communication is both one of the most demanding and difficult aspects of a nurse's job, and one which is frequently avoided or done badly although being central to the quality of patient care." Fielding and Llewelyn have also stated that nurses would rather carry out their administrative tasks than interact with patients and that it is the lower category carers who communicate the most with the patients. The nurses referred to in this study were all professional nurses. Fielding and Llewelyn's statements apply in the South African context. Woodward states that it has been suggested that the emphasis on cognitive skills may inhibit the affective domain and subdue caring impulses (Krathwohl and Bauman in Woodward 1997). Woodward (1997) suggests that recruits may be motivated by a desire to obtain an academic qualification rather than by a desire to care for others and that this may also result in the loss of care as a core value.

d) expectations of the nurse and other health professionals

The women expected the nurse to be knowledgeable and to have skills. Skills such as assisting with feeding, washing patients and caring for pregnant women were mentioned. She should be conscientious about her work and demonstrate caring through her verbal and non-verbal communication. Other expectations were to be treated with respect and to be given an explanation about *'everything, so that you can understand ...'* In relation to respect, age is of particular significance and has strong cultural value and meaning.

In the discussion the women perceived that nurses often could not concentrate on their work because they were giving priority to their personal problems. This was demonstrated in the following statement:

I think its better she leaves her problems at home.

In the focus group interviews the following words were used most frequently. The frequencies are given in brackets.

care and its derivatives (32)

patience (8)

respect (6)

information / explanation (8)

swearing (2)

shouting (17)

rude (12).

These words were used to describe the nurses behaviour and/or to describe what they should or shouldn't do to meet the womens' expectations.

reference to other health professionals

One woman described how she had turned to a doctor to intercede for her. She described how when her sister had been admitted to hospital, she and her family had been left sitting. They waited over an hour and nobody advised them as to what was happening. When she went to enquire she was not given an answer because nobody went to find out. Finally, when she recognised the doctor who had seen her sister, she talked to him. The doctor told her where her sister had been moved to and directed the family.

Another woman stated that she felt safer about going to see a doctor.

No its better to go to the doctor than to go to the nurse.
Feel free to say to the doctor, I've got this and that, than to the nurse.

The blurring of roles and functions of health professionals is problematic for the women. In discussing the importance of health information for the asthmatic person, one woman said that information about possible causative factors is not given, '... *they don't do that. Also the*

doctors are saying its for the nurses.'

The feelings that were most evident in this category were anger and sadness. At times feelings of frustration were expressed.

5.1.2.9 Discussion of findings.

Pascoe (1983) states that there is a lack of standardization in the method of measuring patient satisfaction. He goes on to state that most patient satisfaction studies report that scores are negatively skewed, often leading to statements that patients are satisfied.

Dissatisfaction with the role and function of the nurse is clearly evident in this study. The problem appears to be multi-factorial. There is lack of trust on the side of the community. The women are a disempowered group in the community and this is reinforced in their encounters with health care professionals. They are "scared" to challenge the nurse for fear of retaliation, but at the same time they are dissatisfied with the treatment given. These findings are consistent with those carried out by the Women's Health Project in 1994. The report (1994:15) states that "most of the women in the groups experiences of childbirth have been negative. They had many more negative than positive experiences." The report also makes reference to findings relating to discrimination on the basis of social status. It states that poor interpersonal relations between staff and patient was the most frequently mentioned issue. In contrast, however, the report (1994:20) states that "women said they are not able to express their opinion on the quality of the services." Among the reasons that they gave were that they did not know their rights, that they are scared to complain and that the nurses are unapproachable.

Thorne and Robinson (1988:783) state that the "... traditional perspective of trust may have been overly simplistic." In their study the respondents stated that health care professionals did not generally understand or even care about the patient's perspective of his own best interest. The relationships were characterised by feelings of anger, suspicion and intense vulnerability. They found that selective information-giving is sometimes practised as a means of fostering

and maintaining trust. In this study selective information-giving was demonstrated in the following statement:

" When I went to the clinic they just say - Its painful? - I say yes." Furthermore, selective information-giving is seen to be practised by the nurse in the process of translating information to the doctor. One woman expressed it in these words - " ... And then instead of translating the correct way, ... she will change our words." Inadequacies in information giving was reinforced in the responses of final year students (vide 5.3.1.2.17 p 216). The students felt that patient education was often above their level of understanding and was not always done in a sensitive manner, e.g. in the case of revealing a woman's HIV status. Other barriers that the students identified in the giving of information were the workload and difficulty in communication. The need for interpreters was identified by the students.

Risser (Hinshaw and Atwood 1981) defined patient satisfaction as an evaluation criterion for nursing care. Her framework makes use of three aspects, viz. technical-professional factors, trusting relationship and education relationship. The first aspect includes technical abilities and a knowledge base to competently complete nursing tasks; the second includes characteristics that allow for a comfortable nurse-patient interaction and communication and the last provides for the nurses ability to provide information for patients. This includes answering questions, explaining care and demonstrating techniques. This framework could be used to analyse data from this study. Risser's first aspect was described by the women in terms of the lack of thorough assessments. The second aspect received much attention in the descriptions of the poor nurse-patient interactions and the dissatisfaction with the communication between the women and the nurses. This aspect appeared to receive more attention than the first. In Risser's last aspect, the women described the need for information and explanation regarding their problems and care and the inadequate and inappropriate demonstration and information was evident.

The women perceived an expectation of non-compliance on their part from the nurses. This

group of women have a high incidence of illiteracy. Hussey and Gilliland (1989) state that low literacy and illiteracy are major contributing factors to noncompliance, but they do not equal low IQ or intelligence. It is important that nurses take note of this, because the women in this study clearly feel inferior. Compliance is improved when information and explanations are given and the women identified this as a need in their care. In addition, increasing patients' knowledge and skills is an important component of empowering them (Gessner 1989). Major events stimulate an adult to learn (Gessner 1989) and nurses should make the most of this opportunity, especially in the illiterate. Graydon, Galloway, Palmer-Wickham, Harrison, Rich-van der Bij, West, Burlein-Hall and Evans-Boyden (1997) state that patients with early disease have greater information needs than those with advanced disease. This suggests that patients information needs are not all the same. The same authors quote Messerli et al who state that there is evidence to suggest that following mastectomy women have unanswered questions about their treatment, but do not know exactly what to ask. These two factors are important considerations for nurses when giving information.

Not only do patient information needs differ, but so do patients and professionals perceptions of caring behaviour. Larson (1987) compared perceptions of cancer patients and nurses. She found that both groups scored five items in the top ten mean score. These were gives a quick response to patient's call; gives good physical care; puts the patient first; listens to the patient; and talks to the patient. The nurses gave higher ranking to items such as touch, allowing the patient to express feelings about the disease, getting to the patient as an individual and including the patient in planning. The patients gave higher ranking to knowing how to manage equipment, knowing when to call the doctor, being well organized and giving medication on time.

Cronin and Harrison (1988) reported on myocardial infarction patients perceptions of caring behaviour. For these patients the behaviours most indicative of caring were those which focused on the monitoring of the patient's condition and which demonstrated professional competence. Some of the least important behaviours in this study were what I like to be

called; ask how I like things done; touch me for comfort and understand when I need to be alone.

In this study listening, touch, being responsive to needs and talking to the patients' appeared to be the important factors when the relationship was positive.

Laferriere (1993) reports on client satisfaction with home health care nursing. She states (1993:73) that "clients reported the most satisfaction with the fact that the nurse did not seem too busy to spend time talking with them, that the nurse was efficient in doing his or her work, and that the nurse was patient enough with the client. Clients reported less satisfaction with the understanding of what is needed to stay healthy, the nurse's effort to discuss changes in the client's health since the last visit, and the wish that the nurse would tell the client more about the results of tests and procedures." While this study did not probe the last two mentioned aspects, the findings concur. Laferriere states that clients' lack of satisfaction with information given on how to keep healthy and about test results, is indicative that they want to actively participate in their health and nursing care decision making. Pascoe (1983:202) cites a number of studies which show that "one type of interpersonal skill directly tied to satisfaction is clear communication in the form of adequate, comprehensive explanations."

Pascoe (1983:198) states that "... dissatisfaction is associated with intention to switch services ..." In this study the women expressed a preference to go to a private doctor.

In this study an aspect of womens' expectations of the nurse was that she should be able to remain objective and separate her personal life from her professional life. Yuen (1986: 529) writes that " it could also be demonstrated that where relationships in the home and domestic situation are disturbed, there is consequent impairment of ability to utilize effectively relationships with clients and make maximum use of nursing skills." This may be pertinent to the South African situation where the divorce rate is high, crime is at the forefront of every citizen's mind and the working woman carries a treble workload.

Riemen (1986) found that patients consistently perceived nurses as just there to "do a job". Patients also perceived nurses as being rough, belittling them and treating them as children. In addition, patients perceived no interaction as noncaring, e.g. when nurses were too busy talking to other nurses to take notice of the patient. Women were made to feel like objects when they did not explain and when they weren't interested in what the women said. Riemen reports that not once was an ill-performed technical procedure mentioned as noncaring. When she asked patients to describe a caring and noncaring interaction with a nurse, the patients consistently described the noncaring interaction first. This research concurs with Riemen's observation.

Time appears to be a significant factor in patient satisfaction. Pascoe (1983:200) quotes Aday et al who concluded that "... the two key variables influencing evaluations of convenience are travel time and waiting time in the office and that satisfaction with these convenience factors influences satisfaction with other dimensions of care." In this study time was mentioned in relation to waiting time, the punctuality of the opening and closing times of the service and the length of time nurses took for their tea and lunch breaks.

Brown (1986) identified eight care themes in her study. These are:

- recognition of individual qualities and needs
- reassuring presence
- provision of information
- demonstration of professional knowledge and skill
- assistance with pain
- amount of time spent
- promotion of autonomy
- surveillance.

In this study lack of factors that relate to the above were perceived as noncaring\ caring.

5.1.2.9.1 Caring.

Given the frequency (n=32) with which care and caring were referred to and the attention given to this concept in the literature, caring will be discussed as an issue in nursing.

Caring has been considered and discussed in relation to patient care, caring in education, women as carers and the effects of caring on women and as a concept itself. In all of these discussions attempts are made to give meaning and definition to it. There are probably as many definitions and meanings given to it, as there are authors about caring. There is no doubt however, that it has commercial, lay and professional meanings and that it therefore means different things to different individuals. It appears to be expected in various situations and encounters when it is taken for granted. However, should it be absent or exceptional then the experience can be clearly described. For the purpose of this discussion caring will be discussed as a concept, in relation to patient care and in nursing education. Care in nursing education will be discussed in Section C (vide p 198).

5.1.2.9.1.1 Caring as a concept.

Morse, Solberg, Neander, Bottorff and Johnson (1990) state that caring has been identified as a paradigm unique to nursing. Yet despite efforts to define caring, nurse theorists have not reached a consensus on its meaning, its components or the process of caring (Morse et al 1990:2). Morse et al (1990) reviewed the nursing literature and found that some theorists view caring as an affect and therefore do not consider outcomes. From this review they identified five categories of caring. These are:

caring as a human trait;

caring as a moral imperative or ideal;

caring as an affect;

caring as an interpersonal relationship, and

caring as a therapeutic intervention.

In addition, two outcomes were identified - caring as the subjective experience of the patient and caring as a physical response.

In Kyle's (1995) review of the literature, she considers some of the theoretical perspectives on caring. Kyle describes Leininger's taxonomy of caring constructs in which she proposes that the constructs can vary in emphasis and be used between different cultures. Leininger believes that care is mainly culturally derived and therefore nurses need to acquire culturally based knowledge and skills to be effective. In contrast to Leininger, Polaschek (1998) speaks of cultural safety. Cultural safety does not refer to culture sensitivity or to cultural practices. Rather it refers to the position of groups within a society. It requires that the nurse becomes "conscientized" about societal factors which influence inter-ethnic relations.

Watson (Kyle 1995:507) makes the assumption that "caring can be effectively demonstrated and practised only interpers nally" because she views caring in nursing practice as a therapeutic interpersonal process. Watson has identified ten "carative" factors that constitute caring. Watson sees these as describing nursing care as a human activity. Wiess views caring as a holistic process which is demonstrated through three components - verbal caring, non-verbal caring, and technically competent behaviour. For caring to occur all three components must be present (Kyle 1995:507). Kitson speaks of the cared-for and the care giver and also identifies three characteristics, viz. that the care giver is committed to provide service until it is no longer required; that the care giver has knowledge and skills necessary to meet the needs and that the relationship is based on one which upholds the integrity of the one cared-for (Woodward 1997).

The writings of some of the authors suggest that caring is an ethic and has a moral dimension to it. Gadow regards " ... caring as a moral ideal which entails a commitment to " the protection and enhancement of human dignity" (Kyle 1995:508). Fry states that for caring to have moral value it must be viewed as good or right. Caring is more than a set of activities; it encompasses the manner in which these activities are carried out (Kyle 1995). Gaut (1986:82) writes that "if caring is intentional human action, the respect for persons will serve as the underlying principle for all caring transactions."

Therapeutic reciprocity has given another dimension to the concept of caring. Marck (1990) states that this dimension is found in the writings of Fry, Noddings, Watson, Thorne and Robinson, Gadow, Yuen and Young. Watson states that "both nurse and patient have the potential to benefit and grow within the caring process" (Forrest 1989: 816).

5.1.2.9.1.2 Caring in Providing Patient Care.

Sourial (1997) states that studies show that patients' and staff's views about caring differ. Patients tend to consider physical care as more important, while nurses consider psychosocial care as being the more important.

Forrest (1989:818) states that "... a particular quality of interacting denotes caring; interaction that often develops from anticipating needs and responding to subtle cues of which the patient may not even be aware." He states that the nurse's ability to care may be influenced by the supervisor, who by demonstrating care towards the nurse and making her feel cared for, increases the nurse's ability to care for patients. Another factor which may influence her capacity to care is the team spirit which exists in the unit. This may influence her capacity to be caring both with patients and her colleagues (Forrest 1989). Behaviours which nurses interpreted as caring from supervisors were when their efforts were recognized through a "thank you" at the end of a shift and when their individuality was recognized as in a "how are you?" In addition, supervisors can act as role models when they demonstrate caring behaviour towards patients and their families (Forrest 1989). Furthermore, for Vaillot the benefits of caring are not one-sided. By giving the self to others, the nurse grows personally (Wolf 1986). Riemen (1986) questions why nurses respond with noncaring behaviours and attitudes. She offers four reasons for this:

- Nurses have always been praised and rewarded for their efficiency and for getting the job done and whether consciously or unconsciously this attitude is conveyed in their actions.
- Nurses themselves have not been valued and cared for as individuals. Instead the medical profession and administrators of the health care system have viewed them as

a means to an end. This concurs with Forrest (1986) that nurses cannot provide care if they do not feel valued.

- When patients enter a hospital they give up some control over themselves and this subordinate role makes them susceptible to being treated as less competent adults.
- With the growth of technology, nurses have become adept at monitoring the machine and the patient attached to the machine has become of secondary importance.

In the researcher's own experience, spending time with a patient for reasons other than carrying out a procedure was often frowned upon and was considered to be wasting time.

Fagerhaugh, Strauss, Suczek and Wiener (1980) have described the impact which technology has had on care patterns. They identify three factors which they describe as complex and interwoven that have resulted in frustration for the public and health professionals alike. These factors are:

- the rapid impact of technology on health organizations and health practices;
- the change in the character of contemporary illness, from acute to chronic;
- the action of economic, social, and political forces on the health care system.

These factors, they argue, have resulted in specialization and the formation of complex relationships, "immense" moral and ethical problems, burnout, depersonalization and soft technology (the need for psychiatrists and psychiatric nurse specialists). This has meant that the patient is often neglected and fragmentation of care has resulted in depersonalizing effects on the patient. In chronic illness, the patient and family may "...bear the major responsibility for management during the non-acute phase of the illness." They suggest that the development of alternative health care approaches, such as natural birth centres, are a response from the public to current health practices.

Moccia (1988) concurs with Fagerhaugh et al. She writes that while measures have failed to contain costs they have had an impact on the personal interactions within the system. At both the patient and provider levels interactions have become distanced. She (1988:31) goes on to

say that "if fragmentation, alienation, and lack of meaningful human interactions continue to pervade the health care system, they will also continue to erode the nature of the nurses' work."

Strauss, Fagerhaugh, Suczek and Wiener (1981) argue that the patient is a worker whose efforts are not recognized. They state that patients do not relinquish taking all responsibility for themselves. They (1981:405) go on to state that "if patients' work as part of the total division and organization of labour were recognized, it might decrease tension and conflict between patients and staff, contribute to more effective nursing and medical care, and finally, facilitate more effective teaching of the patients themselves than is often in evidence at present." The patient's work ranges from caring for his own hygiene needs to giving information and following commands and instructions. Failure to comply with the latter may result in the patient being scolded. Strauss et al (1981) state that the judgement of patients is not one-sided, for patients also judge nurses. They consider the implications that patient's work has for nursing care. They (1981:411) state that this concept of patient's work should be "... built into the teaching of patients and their kin. Good teaching ought to be based on how these chronically ill patients, when at home, manage their illnesses, symptoms, regimen, and lives. Furthermore, it should involve discovery of what the patients are anxious about ..." Strauss et al (1981) state that while they consider the emphasis on patient teaching to be correct, they have several points to make in this regard. Firstly, that patients are increasingly being taught to manage their own care while in hospital and not only once they are at home; secondly patients are taught from " ... a perspective that is not always conducive to recognition of the equal part that patients play in the work of their care." Thirdly, nurses tend to teach from a patient's perceptions of his needs and from her perception of his needs for knowledge and skills. This dual perspective often prevents her from achieving full understanding of what is transpiring between her and the patient. Lastly, in the case of chronic illnesses cognisance is not always taken of the vast amount of knowledge that these patients often already have (Strauss et al 1981:411).

Given Forrest (1989) and Fagerhaugh et al's (1980) statements regarding the importance of feeling cared for as nurses and the complexity and fragmentation of the health care system leads one to question how nurses demonstrate caring behaviours. Wolf (1986) quotes Fromm who equates caring with love. For him, basic elements common to all forms of love are care, responsibility, respect and knowledge. "Caring and caring behaviour may be associated with responsibility for the person, respect for the person, and knowledge of the person" (Wolf 1986:85). Montagu argues that for people to be caring they must have been cared for from birth. This has implications for health care providers (Wolf 1986). Mayeroff perceives caring as helping people grow and describes the major ingredients as knowing, alternating rhythms, patience, honesty, trust, humility, hope and courage (Wolf 1986). Wolf (1986:91) identified the ten highest caring behaviours to be:

- attentive listening
- comforting
- honesty
- patience
- responsibility
- providing information so that the patient can make informed decisions
- touch
- sensitivity
- respect
- calling the patient or client by name.

In the instance of miscarriage Swanson-Kauffman (1986) identified five caring categories. These are:

- knowing - this was the woman's need to be understood for the personal meaning of the loss in her life.
- being with - this goes beyond knowing to actually feeling with the woman. This correlates with Watson's philosophy that true caring cannot exist where individuals stick to their roles of being nurse and patient. Swanson-Kauffman (1986:42) says that "for

health care professionals this means dropping the professional facade and willingly entering into an emotion-laden, person-to-person relationship."

- doing for - the woman's need to have others do for her during this time.
- enabling - caring that facilitates the woman's capacity to grieve and get through her loss.
- maintaining belief - the woman's need to have others believe in her capacity to get through the loss and to ultimately give birth.

In the provision of patient care, culture cannot be ignored. Leininger (1997) describes how nursing has lacked insight in two critical concepts - nursing was influenced by the medical model where diagnosis and treatment are isolated from culture and secondly, care as the essence of nursing and as a basic human need was not acknowledged. In her vision for the 21st century, Leininger anticipates greater world wide population movement than ever before. Thus she predicts that nursing will become more transcultural and that this will demand changes in both the education and practise of nurses. In the education of nurses, she does not only relate cultural diversity to patient care, but also to academic exchange programmes and service projects. In addition, she states that culture care knowledge impacts on academic administration and public policy. She describes culture and care as "extremely complex phenomena". As the community becomes more aware of their rights and starts to demand quality nursing care, respect for cultural values and beliefs will be expected. Professional caring will have to take cognisance of alternative health practices and services. Thus culture sensitive care is an essential component of the curriculum for the learner and facilitator of nursing and midwifery education.

5.2 SECTION B - FINDINGS RELATING TO THE REGISTERED MIDWIFE

In this section the resources, both human and material, for the undergraduate programme are described. It also includes findings relating to the questionnaire given to registered midwives in the Johannesburg Hospital where students do the majority of their midwifery practical hours.

5.2.1 DESCRIPTION OF RESOURCES

Human resources within the faculty for nursing education number eight full time members of staff and two full time secretaries. In addition to the full time staff use is also made of six part time academic staff in the undergraduate programme. The contribution of the part time members of staff is largely in the area of clinical teaching and clinical supervision. For the purposes of this study only the full time members' qualifications will be described.

5.2.1.1 ACADEMIC AND PROFESSIONAL QUALIFICATIONS OF TEACHING STAFF

5.2.1.1.1 Head and Professor of Nursing BCur (I et A)(Pret) BA(Cur)Hons MA(Cur) DLitt et Phil (Unisa) DNEd(Pret) RN RM CHN RNA RT

5.2.1.1.2 Senior Lecturer BSc(Nursing) PhD DNEd DipIntNCert Neurmed/surg Nursing (UK) RN RM RT CHN RNA

5.2.1.1.3 Senior Lecturer BA(Cur) (Unisa)MSc(Nursing) DNEd RN RM RT CHN RNA DOTT

5.2.1.1.4 Senior Lecturer BSc(Nursing) MSc(Nursing) DNEd Dip Adv Nursing Sc RN RM RPN RT RNA CHN (This lecturer is responsible for the teaching of midwifery / women's health.)

5.2.1.1.5 Lecturer B(Cur) BA(Cur)(Unisa) MSc(Nursing) DNEd RN RM CHN RNA RT

5.2.1.1.6 Lecturer BA(Cur)(Unisa) RN RM CHN RT

5.2.1.1.7 Lecturer BA(Cur)(Unisa) MSc(Nursing) RN RM RPN R ADV PN CHN RT

5.2.1.1.8 Senior Tutor BA(Cur)(Unisa) RN RM RT CHN RNA

5.2.1.2 TEACHING RESOURCES IN THE PRACTICAL SITUATION

Senior lecturer

Registered midwives

Obstetricians

Clinical tutors from the nursing college

5.2.1.3 PHYSICAL AND MATERIAL RESOURCES AVAILABLE FOR TEACHING

While the department of nursing has access to equipment in the faculty, the following resources are classified as "departmental". For the purposes of this study, only resources relevant to the teaching of midwifery will be described.

5.2.1.4 Laboratory Resources

One four bedded clinical learning laboratory

Two Resusci-Annes

Two obstetric models

Four bony pelves

Ten foetal skulls

Three dolls

5.2.1.5 Classroom Resources

Two classrooms that can each accommodate thirty persons

Two television sets

One video recorder

Videos

Overhead projectors

Blackboards

Whiteboard

Flip chart and newsprint

5.2.2 ANALYSIS OF QUESTIONNAIRE GIVEN TO REGISTERED MIDWIVES AT A LARGE ACADEMIC TEACHING HOSPITAL

5.2.2.1 INTRODUCTION

There are 102 posts available for registered midwives in this unit. Of these 30 are senior professional posts and 72 are professional posts. The unit provides care to low risk and high risk patients and also functions as a referral centre. (Vide 5.1.1.1 p 123 for a description of the setting.)

The questionnaire was distributed to all the midwives working in the unit (vide 4.2.2 for a description of the methodology and Annexure F for the questionnaire). Sixty-six questionnaires were returned. Two were incomplete and were discarded. The response rate was calculated on 64, giving a 62,7 percent response.

5.2.2.2 Age

Table 5.8 Age distribution of registered midwives (N=64)

YEARS	N
18-21	1
22-25	18
26-29	9
30-33	15
34-37	12
38-41	2
42-45	3
46-49	1
50-53	1
54-57	1
not answered	1
	64

From this table it can be seen that the majority of the midwives (n=54) were between the ages of 22 and 37 years.

5.2.2.3 Midwifery Registration

The majority of the midwives had obtained their registration through the one year diploma (33 or 51,6 %), followed by the four year diploma (20 or 31,3 %). Ten had a four year degree (15,6 %), two had advanced midwifery diplomas and one had a three and a half year diploma. When age was further analysed against type of midwifery registration it was found that in the 22-25 year age group, two had the one year diploma, nine had the four year diploma and seven had a four year degree. In the 30-33 year age group, eleven had the one year diploma, three had the four year diploma and one had a four year degree.

5.2.2.4 Place of midwifery experience as a student

Some gave more than one response to this question and four did not answer the question. Twenty-one (32,8%) had gained their basic midwifery experience in the unit. Eleven (17 %) had studied at another academic unit close to the city. Of the remaining hospitals, nine are affiliated with universities. Eleven (17 %) said that they had done some practica in community clinics. Overall most of the experience gained as students had been hospital-based.

5.2.2.5 Experience as a registered midwife

Table 5.9. Number of years of experience as a registered midwife (N=64)

Years	N
0-3	31
4-7	18
8-11	7
12-15	4
16-19	3
20 or more	1
	64

Thus almost half of the midwives (n=31) had only 0-3 years of experience as a registered midwife. This may be important when one considers that this is a teaching hospital. Students are being taught and supervised by care givers who themselves have limited practical experience.

5.2.2.5.1 Where most experience was gained

Four responses were eliminated as the respondents gave more than one response. Fifty-seven (89%) stated that most of their experience had been gained in hospital practice and three (4,7%) in clinic practice. Two of the three were in the 22-25 year age group and the remaining one was in the 42-45 year age group. Thus it would seem that the older midwives, while perhaps having more years of experience, do not have community or clinic experience. Those having 12 or more years of experience have all obtained their midwifery registration through the one year diploma. This may have implications for nursing curricula, in that midwives in the service need to be kept informed of the aims and objectives of the different curricula and of the student's needs and practical requirements. Final year students implied that this was not the case (vide 5.3.1.2.6.1 p 211). They felt that staff in the wards needed to know what their requirements are and what their level knowledge was.

The most experienced midwives were those who had obtained a one year diploma and most of their experience had been hospital-based.

Overall, the registered midwives working in this unit are essentially prepared for hospital-based midwifery. This is further emphasised in their post-registration experience as 89% stated that this had been in hospital practice. This means that in preparing students for community-based practice and primary health care, these midwives lack the practical experience.

5.2.2.6 Midwives perceptions of patients needs

A need was not defined for the respondents. Thus in answering questions relating to needs,

interpretation is subjective for each respondent. These were open-ended questions and therefore responses have been grouped. Figures given in brackets refer to the frequency with which comments were made.

5.2.2.6.1 Needs during pregnancy

The most frequently stated need related to education (about pregnancy, diet, exercise and labour) (38). This was followed by the need for emotional support (17). Fifteen stated that the patient has psychological needs including the acceptance of and adjustment to pregnancy. Adequate, early and effective ante-natal care was stated sixteen times. Related to this was the need for basic health care including information about progress (8). The need for a balanced diet was given eight times. The remaining responses related to the health care system and the care-givers: access to hospital and clinics (4), caring environment (3), quality care (4) and mature midwives, sensitive to needs (3). One did not respond to the question.

5.2.2.6.2 Needs during labour

The most frequently stated need related to the need for support - from staff and from a support person (48). This was followed by the need for comfort and pain relief (22). Eighteen stated the need for close monitoring and in nine responses this was linked to competent nursing personnel. Eleven stated the need for education about labour and information about progress of labour. The only other physical need highlighted was the need for hydration and nutrition (8).

The remaining responses related to the health care system - access to adequate facilities (4), caring environment (6) and access to high care facilities (2). Two did not answer this question.

5.2.2.6.3 Needs during the puerperium

The most frequently stated need was the need for education - about the baby and herself (34). This was followed by the need for a support system (29). Physical needs that were highlighted were the need for assistance with breast-feeding (19), exercise and diet (15), rest and sleep (5),

pain control (4), family planning (2) and the need for prevention of infection and haemorrhage (1). Emotional needs that were mentioned related to bonding and parenting (4) and one mentioned the need for the assessment of depression. The remaining needs related to the health care system - need for postnatal examinations (7), greater community support (3) and baby clinics (5).

One person mentioned the need to include the family throughout.
The greatest need during pregnancy, labour and the puerperium is seen as support (94). This is followed by education. In meeting patients' needs the health care system was mentioned in relation to ante-natal, intranatal and post-natal care.

5.2.2.7 Extent to which midwives perceive that needs are being met

Table 5.10 reflects the extent to which midwives perceive that needs are being met during pregnancy, labour and the puerperium..

Table 5.10. Extent to which midwives perceive that needs are met during pregnancy, labour and the puerperium (n=64)

	Pregnancy		Labour		Puerperium	
	N	%	N	%	N	%
Completely	7	10,9	11	17,2	16	25,0
Almost completely	45	70,3	34	53,1	27	42,2
Hardly at all	11	17,2	18	28,1	14	21,9
Not at all	1	1,6	0	0	4	6,3
Not answered	0	0	1	1,6	3	4,6
	64	100	64	100	64	100

The majority of the midwives felt that needs are almost completely met during pregnancy and labour and therefore age and type of midwifery registration did not appear to influence their perception.

Generally, respondents did not address the question, viz. needs. In all three periods comment was made of the patient load as influencing the meeting of needs. In response to needs during pregnancy, additional comments related to the fact that patients book into clinic late and that many do not make optimum use of the facilities offered. Education of the patient appears to be of concern in that it is seen as one of the greatest needs of the pregnant woman, but reference is made to the proportionately few patients who make use of ante-natal classes, the number of unbooked patients, the lack of time to establish rapport with patients and the early discharge from hospital.

In meeting needs during labour, reference was made to the attitudes of the staff and one respondent noted that some women have no support system during labour. During the puerperium it was felt that needs were not met given the short stay in hospital post-delivery. In all three of the above time periods there is no reference to the patients' needs in terms of religion, culture, individualised care, client preferences or informed consent.

5.2.2.8 Perceptions of the role and function of the registered midwife

5.2.2.8.1 Ranking of roles and functions

Respondents were asked to numerically rank a list of roles and functions related to the midwife in order of importance as they perceived them. Six respondents who answered this question had to be excluded because they crossed all the categories; two did not answer this question and one stated that she functions in all areas. Table 5.11 demonstrates the perceptions to this question.

Forty-two respondents (65,6%) see the major function of the midwife as care-giver. This function relates to the greatest perceived need of the patient being support. This response did not appear to be influenced by age, the type of midwifery registration or years of experience. Respondents were not asked to explain what they meant by care-giver and therefore it cannot be stated whether this included technical skills and competence or whether it meant something else to them. For the purpose of this study it was taken at face value.

Table 5.11. Numerical ranking of the perceived importance of the rol nd functions of the midwife

Ranking	Caregiver	Teacher	Administrator	Researcher	Policy Maker	Role Model	Independent Practitioner
1	42	6	1	4	1	3	10
2	9	23	5	1	3	6	13
3	3	14	5	5	2	17	8
4		11	11	5	4	14	6
5		1	19	9	7	8	3
6	1		5	13	25	1	2
7			6	14	12	5	8
8				2			1
N	55	55	52	53	54	54	51

The second major function of the midwife is seen as teaching. Twenty-nine (45,3%) of the respondents ranked this function as first and second in order of importance. This appears to relate to the perceived education need of the patient. Twenty-seven of these respondents were in the ages 22-33 years and does not appear to be influenced by the respondents' years of experience. It is not possible to determine whether the type of midwifery registration influences this response because of the unequal distribution of midwifery registrations.

Her role and function as researcher and policy-maker are seen of lesser import. The role of researcher is ranked last by 42% and that of policy-maker by 57,8% of the respondents. The small number in the sample does not make it possible to state whether age and\or type of midwifery registration influence this response. The number of years of experience do not appear to increase the rating of the role of researcher. While this would need further research, it does have importance for nursing education. If we are to produce lifelong learners and critical thinkers, then the role and function of the midwife as a researcher needs to be developed.

The midwives perception of being a role model assumes a middle of the road ranking by 31 (48,4%) of the respondents. Age and type of midwifery registration do not appear to influence this response.

It would appear that midwives over the age of thirty view the role of independent practitioner as more important than their younger colleagues. While this does, however, need further investigation, it may have implications for nursing education and curriculum development.

5.2.2.8.2 Factors which prevent the midwife from fulfilling her role

Respondents were asked whether there are any factors which prevent them from fulfilling their role adequately. Five stated that there were none. The responses can be clustered into three main categories - patients, staff and the health care system. In terms of the patients, factors which hinder her role and function are the staff - patient ratio and the difficulties experienced in communication. It was felt that the staff are not given sufficient support and opportunity. In terms of the health care system the hospital's function is not well defined. It functions as a primary and tertiary institution with teaching and research responsibilities. This together with the availability of technology and medical support means the role of the midwife is blurred.

Ninety-two percent stated that there are factors which prevent her from fulfilling her role adequately. Factors given show evidence of a lack in job satisfaction and burnout.

5.2.2.9 Education of the student midwife

5.2.2.9.1 Awareness of year of study, curriculum and teaching responsibility

With reference to the education of the student midwife the respondents were asked to state whether they were aware of the students year of study, the curriculum and of their teaching responsibility. Five did not answer this question and one was incomplete. Table 5.12 demonstrates the responses.

Table 5.12. Awareness of the year of study, curriculum and teaching responsibility (n=58)

		always	almost	sometimes	never
11.1	year of study	31	16	8	3
11.2	knowledge of curriculum	17	21	16	4
11.3	teaching responsibility	30	13	11	4

Responses indicated that the midwives are aware of the year of study of the student, have knowledge of the curriculum and are aware of their teaching responsibility. Given that these aspects relate to education it would have been expected to find a greater percentage of midwives ranking their teaching responsibility higher.

5.2.2.9.2 Extent to which midwives can function as change agents

The respondents were asked the extent to which they felt that midwives could function as change agents at various levels of policy making. Table 5.13 demonstrates the responses. Two questions were incomplete and were therefore disregarded.

Table 5.13. Extent to which midwives can function as change agents (n=62)

	level of policy making	always	almost always	sometimes	never
12.1	national	25	17	10	10
12.2	regional	28	15	16	3
12.3	local	42	14	6	0

The majority of the respondents felt that midwives can function as change agents at a national level (67,7%), at regional level (69,3%) and at a local level (90,3%).This is not consistent with the perception of the role and function of the midwife where her role of policy-maker was ranked very low by the majority of the respondents (57,8%).

Because the majority of the midwives responded to the "always" and "almost always" options,

it is not possible to say whether age, type of midwifery registration or years of experience influenced the response.

5.2.2.10 Other comments

The final question was an open ended question allowing for any comments. Forty respondents did not comment. Comments given related to education and job satisfaction. Educational needs related to the midwifery curriculum, the need for clinical support for students and the need for in-service for registered staff. Poor job satisfaction was evidenced in the use of the words - lack of motivation, criticism from authorities, little enthusiasm, not recognized as a profession, low pay and overwork, not credited for amount of responsibility carried, not given a chance to function as change agents.

The above descriptions are also suggestive of professionals who have a poor self-image. Fulton (1997) quotes Roberts and Hedin who have described the destructive behaviour which manifests in the profession when nurses who are struggling to cope with situation, internalize the negative messages about themselves. This may be manifesting in this group of midwives. They are perceiving negative messages about themselves and the lack of motivation and enthusiasm they recognise in themselves is resulting in poor patient care and inadequate support of the student (vide 5.3.1.1.13 p 207 and 5.3.1.2.3 p 209).

5.2.2.11 CONCLUSION

The profile of the registered midwife working in this unit may be described as a young person (20-25 years), with little post registration experience (0-3 years). She recognises her teaching responsibility (evidenced by the responses to patient needs and the education of the student midwife), but appears to have difficulty in meeting this responsibility (refer questions 8.2, 9, 10 and 12). In addition, her midwifery education and post-registration experience has prepared her for hospital practice and she therefore is inadequately prepared to help in the education of practitioners for primary health care. Areas in which she could be assertive or make an impact on patient care, viz. administration, research and policy-making, are not priority roles

for the majority of the respondents.

Respondents named patients, staff and the health care system as being factors which prevented them from fulfilling their role adequately. In a study undertaken by Morrison (cited in Sourial 1997), nurses described how they held back in relating to patients in order to prevent themselves becoming emotionally and physically exhausted.

5.3 SECTION C

In this section the students perception of the curriculum was evaluated. Part of this section of the study formed part of a larger study being undertaken in the faculty (vide 4.2.1.3 p 110.)

5.3.1 FINDINGS RELATING TO THE CURRICULUM

5.3.1.1 ANALYSIS OF QUESTIONNAIRE GIVEN TO ALL STUDENTS IN THE B.NURSING PROGRAMME

This questionnaire was compiled together with senior researchers in the faculty, with the researcher giving nursing input. The reason for this was that it formed part of a larger research within the faculty that was evaluating student perceptions regarding the various professional degrees offered. The overall objective of this was to design outcome competencies for the various degrees. At the time that this evaluation was being planned, a curriculum in women's health had not yet been considered although women's health per se was talked about.

The process was evaluated by means of a questionnaire (See Annexures G and H). The questionnaire was distributed to students registered for the B. Nursing degree in 1994. A total of 67 students completed the questionnaire. Ninety-one students wrote examinations towards this degree in 1994. Thus there was a 73,6% response rate. The distribution of students was as follows:

22 of 35 first year students

12 of 17 second year students

20 of 21 third year students
13 of 18 fourth year students.
Of the 67 only four were males.

For the purpose of this research, only those questions which have relevancy to midwifery education and practice will be discussed.

Midwifery is taught in the third and fourth years of study. Students often enter the third year of study with the perception that this year of study is a "walkover". The reason for this perception is that the first two years of study have a heavy science component - they include chemistry, physics, anatomy and physiology, as well as two social science courses. These observations are consistent with Hagell's (1989) writings. She writes (1989:228) that "although nursing is concerned with caring, it has relied heavily on scientific knowledge to define its knowledge base." She goes on to state that the increase in scientific medical knowledge resulted in the decline in the status of other health care providers because their knowledge was not considered scientific (1989:229). As medicine has developed it has become associated with status and prestige. Nursing, although closely aligned with medicine has received little status. Hagell (1989:229) believes that in an effort to improve its social position, nursing has imitated medicine's use of science. This may explain the attention which students give to their non-nursing subjects. The emphasis on the non-nursing subjects is reinforced by the South African Post-Secondary Education requirements. This regulating body will be discussed further in chapter seven (vide 7.2.1 p 275). The first year students who have not done physical science at school find the chemistry and physics courses difficult. For the second language students, the social sciences pose a problem. The physiology course is demanding and requires good understanding of the content if the student is to be successful. Needless to say the first two years are characterised by a high failure rate. The first year also sees a number of students leaving the course either because of failure or because they have reconsidered nursing as a career. These young people are working hard, both academically and in the practical situation, for little or no reward. On the other hand their peers who have

entered other fields of study or career opportunities are having fun and enjoying their youth. During these two years it has been the perception of the staff that the nursing subjects have taken second place in the students' priorities and they have spent the minimum amount of time on them. When they pass these subjects their attitudes towards these subjects appears to be correct and as a result when they enter third year, where three of the five courses are nursing courses, they perceive that this will be an easy year. The first two years of study which have a high failure rate create a sense of battle in the students and so when they enter the third year a mood of survival and "having made it" appears to exist. Once students have made it to the third year of study it is unlikely that they will not complete the course. The third year students often appear disinterested and demotivated to the staff. Their attitude appears to be one of "hanging in" as its nea[illegible]s in this year too, that group conflicts come to a head and lack of group coh[illegible]y is obvious. Usually a situation occurs which results in the expressic[illegible]roup spirit improves. For these reasons the third year students are gene[illegible]t perceived to be an easy group to teach.

The fourth year of study is characterised by a sense of completing requirements, coping with four major subjects and practical work. In the practical they are senior students and they are given a fair amount of responsibility. Personal feelings which the students describe are what am I going to do next year?, a realisation of the loss of peer and group support, the realisation that they will be on their own and will not have departmental staff for support. Generally, they experience feelings of loss. While they are more committed to their studies, the pressures do affect their physical and mental health and the staff need to be caring and provide support and encouragement.

This department's experiences do not appear to concur with Heyman et al's findings (Weller, Harrison and Katz 1988) that nursing students become more attracted to their profession and identify more closely with it as they progress from year to year. In the researcher's experience, this only becomes apparent during the fourth year of study.

Murray (1983) found that intention to leave nursing was strongest among third year students. She also found that conflict was highest among second and third year students. This she attributes to increased awareness of public demands with which the students felt unable to cope.

5.3.1.1.1 Age Range

The age ranges for each year of study were as follows:

first years: 19-25 years;

second years: 20-23 years;

third years: 19-25 years;

fourth years: 21-26 years.

5.3.1.1.2 Life Experiences

Given that some students had had previous experience before commencing the course, a ,stion was directed towards previous life experiences. The majority of the students, 64% ,43) had entered the course directly from school.

5.3.1.1.3 Home language

The majority of the students, 55%, stated that English was their home language. The remaining 45% felt that their greatest difficulty with English were in the areas of talking to others and in written work. In the third and fourth years of study, 13 of 20 (65%) third years and one fourth year stated that English was not their home language.

5.3.1.1.4 Volume of work

With reference to the volume of work for midwifery, 18 of the 20 third year students perceived the volume of work to be reasonable and two felt that it was excessive. Of the 13 fourth year students, one felt that the volume was too little, eleven that it was reasonable and one that it was excessive.

When this variable was analysed against home language ten of the thirteen students in third year whose home language was not English felt that the volume of work in the third year was reasonable and three felt that it was excessive and the one fourth year student felt that it had been reasonable. When home language was analysed against volume of work for the Midwifery I course, 12 of the 13 third year students felt that it was reasonable and one felt that it was excessive (this was the student whose home language was not English). The fourth year student, whose home language was not English, felt that the volume of work for Midwifery I and II courses had been reasonable.

5.3.1.1.5 Relevancy of the subject

All the students in the third and fourth years perceived the subject to be extremely relevant. Subjects which were perceived to be of little or no relevance to the third and fourth year students were chemistry, physics and sociology. All the students in the third and fourth years, irrespective of home language had found the content of the Midwifery I course to be extremely relevant. The 13 students in fourth year had all found the content of the Midwifery II course to be extremely relevant, irrespective of home language.

Kelly (1997) reports that students' perceptions of the nursing courses has more influence on the students' course outcome than does the use of a learning strategy.

5.3.1.1.6 Need for an African language

The need for an African language to be included in the curriculum was strongly felt over all four years of students. Fifty-nine students, 88%, in total felt the need for this.

5.3.1.1.7 Communication and interviewing skills

The importance of this was viewed as being very or quite important by 66 of the students. Thirty-four of 66 students (51,5%) viewed their opportunity to learn these skills as little or hardly any opportunity, as compared with 32 of 66 (48,5%), who said that there was a lot or quite a lot of opportunity. Of the 13 students in third year whose home language was not

English, seven felt that there had been enough opportunity to learn communication skills and 6 felt there had not been enough opportunity. The one fourth year student whose home language was not English felt that there had been quite a lot of opportunity to learn these skills. The fact that there is only one student in this category makes interpretation impossible. However, eight of the remaining 12 students also felt that there had been quite a lot of opportunity. It is possible that by the time students have had more opportunity to practice these skills in courses such as psychiatric nursing, research methodology and midwifery, that there has been quite a lot of opportunity.

5.3.1.1.8 Structure of the course

The structure of the course appeared to be segmented to 43 students and a little segmented to 23 students. This mattered to 11 of the 13 (84,6%) fourth year students. The segmentation of the course also led five of the fourth year students to see the curriculum as leading them to specialised learning as compared with general learning. Topics in which the majority of the fourth year students would have liked increased emphasis are health promotion (7), preventative nursing (8), counselling skills (8), family care (9) and community-based health care (9).

5.3.1.1.9 Method of instruction and assessment

80,5% of students over the four years of study had experienced the lecture method as the most common method of instruction. In the first three years of study, multiple choice questions, essays, short answer questions, clinical examinations, projects and OSCE's were viewed as being the most frequently used forms of assessment. In the fourth year, clinical examinations and projects were seen as the most frequently used forms of assessment. Thirty-four (50,7%) students felt that projects and case studies were the best forms of assessment. Generally, these were seen as the best forms of assessment because they encouraged research and allowed the student to determine the depth of study. Multiple choice questions are the least liked method of assessment, mentioned by 26 students (38,8%). Short answer questions are preferred to multiple choice questions because they test factual knowledge, are not as limiting and allow

the student to give some reasoning. OSCE's were disliked by 31,3% of the students. Reasons against them related to the time structure and the physical set-up for the exam. Students stated that the time structure creates anxiety and the setting is artificial and not representative of reality. These factors do not allow them to demonstrate their real capabilities. The fourth year students were asked to identify the extent to which clinical assessments test knowledge, skills and attitudes. Seventeen of 18 students (94,4%) replied "most of the time" to this.

Of the 13 students in third year whose home language was not English ten felt that race influences assessment outcomes, 11 felt that gender does not influence assessment outcome and nine felt that being a nursing student influences outcomes. It was not surprising to find that ten of the 13 students felt that race influenced outcome because this questionnaire was completed just after the present government had been elected. Thus these findings suggest that students may have felt discriminated against during the apartheid era. This is a sensitive issue and needs to be managed openly and with sensitivity in all teaching.

There being only one student in the fourth year group whose home language was not English, these aspects were not subjected to cross analysis.

However, nine of the fourth year students stated that they found it very difficult to cope with the theoretical and practical components of the course.

An analysis of the final examination midwifery paper in Midwifery I was carried out. The emphasis in this paper is on the normal pregnancy, labour, puerperium and neonate. Examination papers over a three year period were analysed for application and recall of information. The range for application was 72-75% with a mean of 74%. The range for recall was 25-28% with a mean of 26%. The final course results for Midwifery I were analysed for the period 1993-1997. Eighty-five students in total wrote an examination in the subject and over the five years a total of four students failed the course. This gives a failure rate of 4,4% over five years.

A similar analysis was made of the Midwifery II examination papers. The same three year period was used. Two papers are written at the end of the final year. The content of Paper I is of antenatal and labour and that of Paper II postnatal and the neonate. The emphasis over the two papers is on the abnormal. Paper I had a range for application of 73-88% with a mean of 80,3%. The range for recall was 12-27% with a mean of 19,7%. Paper II had a range of 79-85% for application with a mean of 82,3%. The range for recall was 15-21% with a mean of 17,7%. A total of ninety-one students wrote the final midwifery examination over the period 1993-1997. Only one student failed the examination in this period - a rate of 1,1% over five years.

5.3.1.1.10 Problems experienced by students during their studies

The most common problem experienced by students was personal problems (59,7%). This was followed by difficulty with subject matter (50,7%) and experiences with poor teaching (44,8%). The ability to cope with the theoretical and practical aspects of the subject matter was probed in a further question. The first and third years had difficulty in coping with the theoretical component of the course, while more third and fourth years had difficulty in coping with the practical component of the course. This finding may be explained in that the transition from school to tertiary education is difficult, particularly for first years. In the third year of study, two new nursing disciplines are introduced, viz. midwifery and psychiatric nursing, both of which require a maturity of the student. This aspect may also explain why the third year students find the practical aspects of the course difficult. The fourth year students have difficulty in coping with the practica because as final year students the demands made on them are great and they are expected to carry responsibilities which equate with that of a more experienced professional. When home language was analysed against problems experienced during the third year of study, it was found that out of the 13 students whose home language was not English, the following problems had been experienced:

personal problems	10
poor teaching	11
poor study methods	9

financial problems	9
difficulty with subject matter	5
sexual harassment	0

Again, there being only one student in this category in the fourth year cross analysis was not possible. However, when the group as a whole was analysed, it was found that the majority of the students had experienced problems with poor teaching (11) and difficulty with subject matter (6).

Kelly (1997) found that a student's perception of superficial teaching correlated with a heavy workload, rote learning, and a learning environment that lacked encouragement, stimulation or responsiveness to students.

5.3.1.1.11 Intended area of practice on completion of degree

Students were asked in which field of nursing they intended practising on completion of their degree. 35,8% intended working in the community and 29,9% planned to practice midwifery. This is encouraging when one considers the need to prepare practitioners for primary health care. However, 41 (61,2%) planned to practice in an urban area. This may relate to the fact that the majority of the students' homes, 73,1%,were in urban areas. Of the 13 fourth year students, nine felt that they were poorly prepared to work in rural hospitals and community settings.

5.3.1.1.12 Geographical location of home town

Of the twenty students in third year, English was the home language for seven. Of these seven, five were from an urban area, one from a peri-urban area and one was from a rural area. It appeared that the same distribution intended practising in these geographical locations on completion of their degree. Of the 13 students whose home language was not English, five were from an urban area, seven were from a peri-urban area and one was from a rural area. On completion of their degree, nine intended practising in an urban area, one in a peri-urban

area and three in a rural area. Eleven of the fourth year students were from an urban area and two were from a peri-urban area (including the student whose home language was not English.) Nine of the fourth year students intended practising in an urban, two in a peri-urban area and one in a rural area on completion of their degree.

5.3.1.1.13 Practical midwifery experiences

Students were asked to evaluate their practical learning opportunities in terms of usefulness and supervision. Thirty of 39 students (76,9%) found their midwifery opportunities to be useful. Nine students (23,1%) felt that the practica was well supervised, while 19 (48,7%) felt that more supervision was needed. Unfortunately this question was incompletely answered by a number of the students. The fourth year students were asked to state whether they felt that the curriculum had prepared them to work in various settings. Almost half (46,2%) felt that the curriculum had prepared them to work in a specialty. The majority did not feel that it had prepared them to work in non-teaching hospitals, rural hospitals and community settings (69,2%; 76,9% and 76,9% respectively.)

Students are currently required to obtain 600 hours of practical midwifery. Of this 40 hours is obtained in a community health centre (Alexandra Health Centre), 40-80 hours at a peri-urban hospital (Carltonville Hospital) and the remainder at the academic hospital. Thus only 6,7 - 19,8% of a student's experience may be obtained in a community-based setting.

5.3.1.1.14 Topics which should have an altered emphasis

The fourth year students were asked to state whether they felt that certain topics should have an altered emphasis in the course. Topics which students felt should have greater emphasis were ethics, communication skills, health promotion, counselling skills, social aspects of health, family care, community based health care, and medico-legal aspects.

5.3.1.1.15 CONCLUSION

Demographic data reveals that the profile of the student entering the programme is more likely

to be female. She will very likely be in the 19-25 year age group and she is most likely to have entered the programme directly from school. She is likely to have come from an urban area and there is a chance that her home language will not be English.

With reference to the Midwifery I and II courses students felt that the volume of work was reasonable and that the content of the courses was extremely relevant. There appears to be a need to increase content which relates to primary health care needs, e.g. family care, community-based nursing care and counselling skills. In addition, a shift in practical learning opportunities is necessary as the data reveals that the students do not feel competent to practise in rural hospitals and community settings.

5.3.1.2 QUESTIONNAIRE GIVEN TO FINAL YEAR STUDENTS TO PROBE ISSUES RAISED.

This questionnaire was not planned in the original methodology of this study. (See Annexure I). However, issues, which necessitated further exploration, were raised in the focus groups which described the outcome. It was decided to give a structured questionnaire to the fourth year students at the end of their final year examinations. This was the last group of students to be completing the degree based on the traditional curriculum (vide 4.2.1.3.6 p 112).
The total number of students in this group was twenty. Nineteen students completed the questionnaire.

5.3.1.2.1 Whether midwifery course was enjoyed.

Eighteen students stated that they had enjoyed their midwifery course. Reasons given for this could be divided into academic aspects and the practical aspects. Eleven students stated that they had enjoyed their course because they had found it challenging, structured and comprehensive. Six students referred to the practical component of the course. Here reference was made to helping the community, the enjoyment of working with mothers and their babies and one student felt that she had learnt much about human nature and life.

Only one student stated that she had not enjoyed the course for personal reasons.

5.3.1.2.2 Aspect of course most enjoyed

Eight students stated that ante-natal was the part of the course that they had most enjoyed. Of these, five specified ante-natal clinic and one ante-natal theory. Two stated that they had enjoyed delivering babies and two that they had enjoyed doing the follow-up assignment. Reasons given for enjoying ante-natal clinic were:

- we were dealing with well women; it is a happy event; when problems arose, they were interesting and one could see the effects on the developing foetus.
- staff were approachable (2) and keen to teach (2) - this attitude eased our anxieties; when unsure, I was not afraid to ask.
- because you do a lot in one session with the patient - can pick up problems, deal with them and give education.
- I was able to learn more as I was given more responsibility and decision-making powers. I was able to apply academic work and was treated with respect as fellow staff members.

5.3.1.2.3 Aspect of course least enjoyed

Six students stated their labour ward experience had been the aspect that they had least enjoyed in midwifery. Three students did not enjoy their experiences in the antenatal ward. Three students had felt the pressures of trying to obtain and meet their practical requirements on time. Four students identified aspects of the theoretical component of the course which they had not enjoyed. These were the lectures given by the obstetricians, embryology and the module on comprehensive midwifery (2).

Reasons given for not enjoying their labour ward experience were as follows:

- the staff were not accommodating at all, in fact they were quite derogatory. This made the experience unenjoyable.
- hostile environment - I was constantly feeling that I was not doing anything right.
- the staff had negative attitudes towards students - made you feel stupid - this lead to a lack of interest and dragging your feet to work.

- the theoretical part of labour was wonderful, even delivering babies. The staff in labour ward with their attitudes made my experience horrible because of the way they treat students.
- lecturer went too quickly and I could not write everything down - at times lectures were also confusing, but things were explained well.

One student described how the students had complained to the staff in the antenatal ward about maltreatment. They felt that the response from the staff was poor in that they did not respond professionally and were very emotional.
Referring to the lectures given by the doctors, one student felt that it was good to know information, but she was not able to apply it.

5.3.1.2.4 Irrelevant aspects

Sixteen students felt that there had not been any aspects of the course which had been irrelevant. Of the three who felt that there had been irrelevant aspects, two referred to the section on comprehensive midwifery which they felt had overlapped with community health nursing.

5.3.1.2.5 Aspects which were inadequately covered

Seventeen students stated that there were no aspects which had been inadequately covered. Of the two who felt that there were aspects which needed more attention, one wanted more information on parenting and looking after babies. The second student wanted more information on the actual nursing care of patients as she felt that textbooks do not include all the necessary information. This is consistent with comments made by the graduands regarding breastfeeding and parenting (vide 5.4.1.1.4.1 p 227).

5.3.1.2.6 Supervision of practica

In response to the supervision of midwifery practica, nine students felt that it was adequate and ten felt that it was inadequate. This is consistent with the findings in the previous

questionnaire given to students, where 48,7% felt that more supervision was needed (vide 5.3.1.1.13 p 207).

5.3.1.2.6.1 Suggestions to improve supervision

Students felt that the practical supervision could be improved by:

- encouraging the staff in the wards to become thoroughly involved; having a tutor (5) who was available to come to the wards and deal with questions there and then and evaluate experiences;
- having regular tutors especially in labour ward; more supervised demonstrations and tutorials;
- in labour ward all sisters had different methods of delivery (2) and we should be taught a universal method by a clinical tutor. Getting delivery assessments was impossible because each sister wanted a different technique;
- by telling staff in the midwifery areas what they are expected to do for and with the students (2);
- staff in labour ward and antenatal ward were very unwilling to supervise with our requirements;
- supervision needs to be continuous, should not be left completely on your own with no staff member telling you that your assessments and actions are correct, and
- by gaining the support and willingness to of the labour ward staff to teach and supervise; antenatal clinic was great.

5.3.1.2.7 Suggestions to make learning more pleasant in third and fourth year

Aspects which could have been managed differently in the third year of study to make midwifery learning experiences more pleasant elicited the following responses:

- everything was done perfectly - continue giving problem solving exercises and discussions in a big group;
- abnormal midwifery should be covered in third year;
- more practical supervision before going to labour ward - they expect you to know a lot

on arrival;

- more emphasis in third year on requirements or start practica earlier to avoid stress in fourth year;
- more experience in outside hospitals;
- taught mechanism before going to labour ward and more revision of mechanisms throughout the course;
- demonstrations should be given more frequently, and
- labour ward staff need to be more student friendly.

Aspects which could have made fourth year more pleasant:

- more time in labour ward to get requirements, and each student should have the opportunity to go to Alexandra Clinic, and
- need more clinical guidance and supervision.

Seven students did not answer this question and three stated that they had nothing to add.

5.3.1.2.8 Use made of Carltonville Hospital

Five students had obtained practical experience at Carltonville Hospital. (This is a small town approximately one hour's drive from the city.) Of the 14 students who did not go there, one student, a married student, said that it was not practical for her to be away from home for a week and another felt that it was very far away. The five students who had gone to Carltonville had obtained deliveries, practice in abdominal palpations and vaginal examinations. Only two of the students had cut and sutured an episiotomy there and one said she had been taught how to do the procedure and had practised suturing.

5.3.1.2.9 Use made of Alexandra Health Centre.

Eleven students had obtained practical experience at the Alexandra Health Centre. The married student stated that her husband had refused to allow her to go into Alexandra. She said that they had argued about it because it was a really good learning opportunity. One of

the students who had gone there stated that it was very quiet when she was there and she wished that it could have been more than one week in duration. She felt that it was a good community experience. Of the eleven students who had gone there, all had obtained deliveries and experience in abdominal palpations and vaginal examinations. Eight students had cut and sutured an episiotomy.

The students responses to questions 8 and 9 above are in contrast to the perceptions of the supervisors. The students appear to have gained and grown in these clinical experiences and to have benefited from the opportunities in terms of obtaining their practical requirements. The supervisors who were interviewed in the focus groups did not perceive these opportunities as being of much benefit to the students (vide 5.4.1.2.3.1 p 242).

5.3.1.2.10 Descriptions of settings as learning environments

This question asked students to describe the learning environments of the various settings which were used for their practical experiences. Their responses could be grouped into four main categories for the three sites used, viz. the learning environment, staff, patient care and students.

5.3.1.2.10.1 The main academic hospital.

While this setting was described in negative terms, students recognised the value of the clinical learning opportunities available. Terms used to describe this environment were hostile, unfriendly, unhelpful and unpleasant. Two students described it as "challenging". One said that it challenged her emotionally and spiritually and that she grew as a person.

Students did not perceive the staff as being helpful in terms of obtaining their clinical requirements and one said "you feel like they are doing you a huge favour by teaching you." Labour ward appeared to be regarded as the most unfriendly. Staff here were described as being "tough" and lacking in interest. Antenatal clinic and the postnatal wards were described in positive terms. In these areas students felt that they were allowed to do things by

themselves and felt comfortable about asking for help. Overall the staff were seen as lacking in motivation, having poor attitudes towards students and being unwilling to supervise or teach students.

It was felt that little emphasis was given to patient care, with little consideration being given to patient needs and the development of the nurse-patient relationship. Care was described as "very technical".

5.3.1.2.10.2 Carltonville Hospital.

This setting was described in mainly positive terms. The learning environment was perceived to be lacking in the area of working in a multi-disciplinary team, but the staff were found to be "happy to teach new things."

Patient care was considered to be comprehensive with the same staff being with the patient from admission to discharge.

The lack of sophisticated equipment meant that clinical skills improved.

5.3.1.2.10.3 Alexandra Health centre.

This setting was viewed in a positive light. The learning environment was conducive to the development of clinical skills. Students felt that they experienced the opportunity to learn the management of complications and that the absence of technology reinforced clinical skills. One student said " women can deliver normally without continuous CTG monitoring."

Staff were described as being friendly, supervising and guiding and co-operative in helping students to obtain their requirements.

It was felt that care was holistic, but that there was limited opportunity to learn postnatal care, as patients are discharged within hours after delivery.

5.3.1.2.11 Setting which is most appropriate for the learning of skills

Students were asked which they would consider the most appropriate for learning midwifery skills, and which should be used in the future.

One student did not answer this question and two misinterpreted the question. Five students felt that the basics should be learnt at the main academic hospital and then students should go to other hospitals such as Carltonville. Six students listed a MOU, with five naming Alexandra Heath Centre. One student felt that a unit that specialized in home deliveries would complement the technical methods learnt at the academic hospital.

5.3.1.2.12 Self-evaluation of competency

All 19 students said that they felt competent as a beginning midwifery practitioner. Only one student added tha he still needed some supervision.

5.3.1.2.13 Competency in a hospital setting

All 19 felt competent to practice in a hospital setting. Again one student added that she felt she was competent but with supervision.

5.3.1.2.14 Competency in a primary health care setting

Eighteen students felt that they would be competent to practice in a primary health care setting. Two added "with supervision" and one "with appropriate accompaniment from more experienced midwives." Only one student did not feel competent to practice in such a setting as she felt that she needed more experience especially in the cutting and suturing of episiotomies.

5.3.1.2.15 Areas in which not competent

Thirteen students did not feel that there was any specific area in which they would feel less competent to practice. Six stated that there was. Of the six, five named labour ward and one antenatal.

5.3.1.2.16 Cultural issues and midwifery care

Cultural issues appear to be of significance in midwifery care and practice. Students were asked how they felt that these issues can best be managed or overcome.

Ten students felt that there should be greater emphasis on culture in the course work. One student stated that students should be prepared for this during the entire course (programme) as it has relevance to other areas of nursing as well. Three students expressed a need to learn Zulu or Sotho. One student stated that language was a problem. She went on to say that " when staff do not communicate in English - you feel left out and unable to learn from everyday interactions." Another student related cultural differences to learning. She said "problems with the black staff are not racist, but an example of st[illegible] who feel threatened by our degree course or have no confidence in us."

In relation to patient care, students felt that it was important to acknowledge others' beliefs and values, that it was important to include husbands in the pregnancy process, to give adequate information when asked to do so. The need to use a translator was mentioned, as was the importance of hearing and listening to what a patient is saying and what works for her.

These findings are consistent with the remarks made by the graduands, where greater emphasis on culture and the need to learn an African language were identified as deficits in the curriculum (vide 5.4.1.1.4.2 p 229).

5.3.1.2.17 Perceptions of health promotion

Students were asked how they perceived the giving of information or education to patients. Responses to this question could be grouped into three categories - inadequate information, time and professional attitude.

Six students felt that information giving was inadequate. Students felt that information given was not always relevant or appropriate for the woman's level of education. One student felt

that more interpretors were needed. Information giving was likened to preaching. Another student felt that there was "no truth telling". She felt that incorrect information is sometimes given because of a perception that the truth may distress the patient. The amount of information was also perceived to be problematic. Some felt that too little was given and others, that too much was given at once. One student said that "when giving information we have to limit it or try and make it real to the patient."

Time was mentioned in two ways. One that because of time constraints, information giving was inadequate and the other related to its importance in care and the lack of time given to it. It was felt that in antenatal clinic and in the postnatal wards, time was taken to educate "and mostly in the patient's language." However, another student felt that because information is given in groups, there was no reinforcement of the material.

The non-professional manner in which information was given was noted by five students. One student stated that doctors are abrupt when informing a woman about her HIV status. This they found distressing to observe. Another stated that staff had "reduced the women to tears by yelling at them." One stated that "students don't have good role models". This statement was reinforced by another student who said information giving was "not done very professionally all the time and many professionals forget how important it is to keep patients informed."

These findings are consistent with the statements made by the graduands regarding the provision of health information (vide 5.4.1.1.4.4 p 233).

5.3.1.2.18 Comments

This question gave students opportunity to make any comments they felt they still needed to express.

Responses to this question fell into three main categories - theory, practice and the follow-up

study.

Eight students commented on the theoretical aspect of the course. All were positive comments and referred to the structure and comprehensiveness of the teaching. One student felt that she had a good base from which to work and that she had enjoyed the problem-based and practical approach to the theory. She felt that what was learnt was applicable to the practical situation and that it had been a good way to learn.

Six students made reference to the practical learning opportunities. Comments were more varied here. The most pertinent for this study were "staff need to realise that we are in the wards to learn. They must be aware of our requirements and our level of knowledge. They should be willing to teach us and not expect us to do things beyond our scope of practice" and " the practical was nerve-wracking at times, but that tends to be the case with nursing."

5.3.1.2.19 Discussion of findings.

The main problem in the course appears to be in the practical areas. The main academic hospital is not a suitable learning environment in terms of the willingness of the staff to teach and to help students meet their requirements. At the same time students appear to recognise the value in this setting in terms of the clinical learning opportunities available. There appears to be an attitude of enduring the emotional climate in order to make the most of the opportunities available. This finding is consistent with studies quoted by Chun-Heung and French (1997) which found that student nurses stated that the practice setting is the most influential factor in relation to the acquisition of nursing skills and knowledge. The Carltonville Hospital and the Alexandra Health Centre are clearly seen as good experiences. Factors that are highlighted by the students when describing these learning opportunities are the positive attitudes of the staff, the willingness to teach and the opportunity to participate in holistic care that is not dependent on technology. The registered midwives appear to view midwifery practice as a set of skills which need to be learnt. They appear to base their practice on the medical model. This observation is reinforced by the student's observation of holistic

care.

Chun-Heung and French (1997) quote several studies which have indicated that not all practice settings are able to provide students with a positive learning environment. Chun-Heung and French (1997) interviewed 16 students from eight nursing schools in Hong Kong. The students were at the end of their second year of a hospital- based pre-registration programme. They found that learning was mainly initiated by students themselves and that the qualified nurses' willingness to teach was the most important aspect influencing the student's practice experience. Students enter the profession feeling competent as beginning practitioners. This finding is consistent with the findings of Madjar, McMillan, Sharkey and Cadd (1997:viii) who found that " ... new graduate nurses have high expectations of their readiness to enter the nursing workforce and, in most cases, assess themselves as having the necessary clinical and professional competencies." In this study they also found that the beginning practitioners did not feel that their clinical exposure during their studies had been sufficient.

Windsor (1987) writes that several studies have reported on the importance of faculty behaviours and characteristics to nursing students. Qualities that have been identified as important include interpersonal relationships, professional knowledge and behaviour. Windsor (1987) states that students reported that a pleasant clinical instructor and staff helped them to learn. A pleasant atmosphere helped the students to relax and students were more likely to ask questions or discuss issues in such an environment. These students also stated that personal problems were detrimental to their learning. Students highly valued positive feedback even when they knew that they had done well. In addition, they expressed the need for a knowledgeable clinical instructor. Windsor found that the clinical environment is influenced by the clinical instructor, staff nurses and peers. This study also found that nursing students move through various stages during their clinical experience. Students moved from an anxiety stage (characterised by not sleeping well and feeling nervous), to one they called "make you or break you" (a stage of confusion about the profession) to a final stage of becoming more

confident. More recently, Liegler (1997) studied factors which could predict overall student satisfaction. She distributed 238 questionnaires to students in five baccalaureate nursing schools in California. Her findings revealed that the best predictors of overall satisfaction were students' academic development, satisfaction with facilities and services, satisfaction with the faculty and social interaction with peers. Harvey and McMurray (1997) studied the relationship between attrition and students' perceptions. Their sample comprised of 168 college student nurses in a diploma programme. Problematic interactions with staff in the clinical setting were reported by 21% of the students who continued in the programme. They went on to report that more is involved in the persistence and progress in nursing than actual ability.

Beck and Srivastava (1991) identified sources of stress in 94 baccalaureate nursing students. This study was carried out in Canada. The highest amount of stress related to career choice, academic environment, financial and personal factors. Patients attitudes toward nurses, roommates, dating, alcohol and drug usage were perceived as low stress. Jones and Johnston (1997) administered a questionnaire to two cohorts of students in a generic programme in Scotland. The total sample size was 220. Common sources of stress to both cohorts were fear of failure, lack of free time, long hours of study and college response to student need.

These findings are all consistent with Knowles' statement that "the concept of learning climate also emphasizes the importance of the physical, human, inter-personal and organizational properties, mutual respect and trust among teachers and students" (Chun-Heung and French 1997:456).

In this study comments relating to the witnessing of holistic care and caring that was not technology dependent may be an expression of confusion between what they have been taught theoretically and what they have experienced practically. This finding is consistent with that of Chun-Heung and French (1997) who found that students' experiences indicated that patient care was organized around routines and tasks. In addition, they also found an inconsistency

between what was taught in the school and what was practised in the wards. Kelly (1992) writes that studies have shown that students receive conflicting messages from clinical personnel. She states that "incongruities noted were the classroom emphasis on an individualistic, holistic, caring approach in contrast to task-oriented, technically proficient messages of the clinical learning experience." O'Neill and Dluhy (1997:829) question some of the teaching strategies used. They state that the writing of clinical assignments often includes the development of nursing care plans. They go on to say that "the emphasis on the analytical, linear pattern of the nursing process may actually inhibit prototypic thinking, and de-emphasize pattern recognition skills."

Zerwekh (1990) describes how professional power can be used to empower students. However, in this study it would appear that professional power is disempowering, demotivating and dehumanizing. This concurs with studies which have found that nursing students lack self-esteem (Kelly 1992). Kelly (1992:122) states that there is increasing evidence that this may be related to punitive instructional styles.

5.3.1.2.19.1 Caring in nursing education

It can be argued that if caring is the essence of nursing then the concept of caring must feature in the education of nursing students. Paterson and Crawford (1994) have analysed the meaning of caring in nursing education. They report that caring is cited as the core value in the educator-student relationship. It is assumed that if one knows how to care as a nurse, then one can care for students as an educator. They go on to report that discussions about caring in nursing education emphasize the expectation of mutuality and reciprocity in the caring relationship between students and teachers. In addition, caring is often assumed to be the antecedent to empowering students. On the other hand, few definitions refer to the teacher's competence as an aspect of caring. Caring in the teacher-student relationship is seen as important for two reasons:

firstly, for students to implement caring in practice, it is necessary that they experience caring in their lives and in their educational environment, and

secondly, the empowerment of students to think critically and for themselves requires a trusting and caring environment.

By implication, in their discussions about caring several authors (Dunlop 1986; Pinch 1996; Barker, Reynolds and Ward 1995) have questioned whether caring as an attitude can and should be taught to students, while Woodward (1997) suggests that because recruits have a desire to care, rudimentary caring values are held. Dawson questions the ethics of teaching caring as an attitude especially if caring by students is to be evaluated as part of clinical assessment (Paterson and Crawford 1994:166). As in the case of the nurse caring for the patient, studies have indicated that if faculty do not experience caring in the educational environment themselves, their ability to transmit caring to others was constrained. In addition, nurse educators appear to place lower value on teaching caring than teaching competence (Paterson and Crawford 1994:167). The behaviourist paradigm and the power of the evaluator have repressed the caring aspects in nursing education (Paterson and Crawford 1994).

Diekelmann (1990b) views three concepts as essential to nursing education, viz. caring, dialogue and practice. Paterson and Crawford (1994:166) quote her as saying "... that nurse educators teach out of their practice as nurses. If caring is the essence of nursing, it therefore makes sense that nurse teachers would teach within the context of caring as nurses."

Nelms, Jones and Gray (1993) state that it is a common belief that caring cannot be taught directly. Students learn caring through the role-modelling of the faculty and other faculty-student interactions in the clinical situation and the classroom. They found that students express three themes in caring - time, communication and a combination of the physical and the emotional. Halldorsdottir (Grams, Kosowski and Wilson 1997:10) states that "... the caring teacher-student relationship leads to positive responses to professional caring that encompass a sense of acceptance and self-worth, personal and professional growth and motivation, appreciation and role modelling ..." On the other hand students do perceive caring from their peers. It appears that student-to-student caring relationships involve sharing and

support (Grams et al 1997). Grams et al (1997) identified three patterns when they reported on the use of caring groups as a strategy to learn caring. The three patterns were creating the caring community, experiencing the reciprocity of caring and being transformed. The caring community included the establishment of trust and seeing faculty as part of the group. Experiencing the reciprocity of caring included the sharing of personal stories, concerns and problems and helping each other to get through. Being transformed included learning to know and care for self, learning to care for others personally and professionally, seeing others holistically and becoming more accepting of others.

Watson (1990) calls for "caring knowledge". She states that fundamental to developing a metaparadigm of human caring in nursing knowledge is how person and caring are viewed. She writes (1990:18) that "... we do not and cannot create nursing and caring knowledge in a void." If we do not reflect on this, "then knowledge development takes a simplified approach: we reduce humans and caring-healing health processes to problems to diagnose. Problems become laws, and we begin to empower problems as foci for study and external intervention void of the human and natural landscape, which results in purely technical, mechanical nursing interventions" (1990:19). She goes on to say that it is not enough to be technically correct. She calls for a variety of structures to be used in learning to meet the needs of diverse students and communities. In addition, the value of experiential learning cannot be denied. She states (1990:21) that "... our technocratic knowledge is not the same as our lived human experiences and life processes."

Moccia (1988:32) implies that it is not only technology that has detracted from caring activities, but also "... the dominant ideology and the power relations designed to maintain the status quo." The nature of the current health care system is obstructive to providing opportunity for nurses to be creative in their care of people. She calls for nurses to be aware of the social conditions and to attend to them, if their caring work is to be allowed, valued and recognized.

Benner and Rasanen (Raatikainen 1997) have described professional growth as something which happens stepwise - from novice to advanced beginner and further to competent and expert professional. Raatikainen (1997) studied nursing care as a calling. She found that nurses who had experienced a calling had better knowledge about patients' needs. This was particularly evident in the questions concerning life quality and well-being. Woodward (1997) also writes of a stepwise progression in developing caring attributes. She says that the beginning student has attributes of compassion. Competence and confidence in caring develop during the second and third years of study, while commitment and conscience are only being kindled in third year students.

The emphasis on technology and its influence on the services contributes to the misunderstanding between nursing service and nursing education. Fagerhaugh et al (1980) state that this results in service and education being accusative of each other with regard to competence.

5.4 SECTION D

In this section the opinions of graduands and of their nursing supervisors were obtained as a means of curriculum evaluation.

5.4.1 FINDINGS RELATING TO OUTCOME

Data collection relating to this concept was gathered by means of two focus groups. One group being held with three graduands who had entered midwifery practice (see Annexure I) and the other being held with six nursing supervisors (see Annexure J).

5.4.1.1 FOCUS GROUPS HELD WITH GRADUANDS

5.4.1.1.1 Field notes

This group was held over a lunch hour period. The researcher provided a light lunch and introduced the participants to one another as they had not all been in the same year of study. The group appeared to talk easily to one another. Conversation flowed easily. The dialogue

tended to be dominated by the two graduands who had had the longest experience as registered midwives.

Impressions of the group: One participant was very quiet and was difficult to draw into the group. She had been a quieter student in the classroom setting as well. A second member of the group who had also been very quiet in class spoke freely and it was apparent that she had grown since her graduation and was more assertive. This was the first focus group that the researcher had conducted and she found herself participating in the group discussion too much.

Because of the researcher's participation in the group and the lack of probing of certain issues raised, a second group of graduands was organised. The researcher did not lead this group for two reasons. Firstly, to prevent herself again becoming a group participant and secondly, to allow the graduands to speak freely without the presence of what could be seen as an authority figure / teacher. The most senior of the graduands was approached and asked to lead the group. She was prepared beforehand. Once again this group was held over a lunch hour. The graduands were provided with a light lunch and given opportunity to acquaint themselves.

After the group the leader felt that it had gone well and that everybody had participated well. She felt that some worthwhile recommendations had come from the group.

5.4.1.1.2 Questions which developed from concepts raised in the first focus group

Questions which were developed from the first focus group interview and which were put to the second group related to:

- culture and cultural differences.
- alternative health practices and the giving of information
- breastfeeding
- communication and relating to the patient's level of understanding
- applying theory to practice

- parenting
- difficulties relating to the understanding of the four stages of labour
- perception of midwifery in relation to medicine
- confidence in ability to practice in a primary health care setting
- and issues which could be considered deficits in the curriculum

After the researcher had transcribed the interview she gave it to two members of the group for member checking. They both agreed that it was a fair reflection of the discussion.

5.4.1.1.3 Analysis and findings of the group interviews

Analysis of the raw data was undertaken using Tesch's eight steps as described in the findings relating to the focus groups held with the community women (vide 5.1.2.3 p 154) and in the methodology (vide 4.5 p 119).

The taped interviews were transcribed verbatim. They were read through twice in order to get a feel for what was being said and meant. Key words and phrases were underlined, e.g. culture, language, care, holistic care. Words and phrases that related were then grouped. Sub-categories were identified and were then analysed for commonality. From these categories were identified.

5.4.1.1.4 Categories and sub-categories

The categories and sub-categories which emerged in the analysis of the data were as follows:

A. Learning Environment

a) curriculum issues

b) holistic care

c) becoming a registered midwife.

B. Culture

a) communication and language

b) care and sensitivity

C. Relationship of theory to practice

a) correlation between theory and practice

b) integration of subject matter

c) awareness of actions

d) practical learning opportunities

D. Health Promotion

a) appropriate information

b) client involvement in information giving

c) actions of care givers.

E. Graduands perceptions of current students

a) qualities of the students

b) level of knowledge

c) learning needs

F. Health Services

a) need to be culture sensitive

b) alternative practices in health care

c) provision of obstetric care.

5.4.1.1.4.1 A. Learning Environment

a) curriculum issues

It was felt that the curriculum had not adequately prepared them for the teaching and management of breastfeeding and for the preparation of patients for the parenting role. The graduands were able to offer suggestions as to how these deficits could be overcome.

So I would just like to see that training include some sort of exposure to groups like the La leche League, which is a mothers organisation, teaching mothers about breastfeeding. ... a group like that would help, you see, mothers and talk to mothers who are breastfeeding further on into breastfeeding than just the beginning period. .. Often they'll identify practices for students that are wrong in the hospital situation.

Certainly it would be useful as a young midwife starting out to have some information about parenting. Some general principles rather than the specifics. Ummm, on what a good parent is and what advice you could give and what education you could give parents.

... there's groups li ... I think STEP is one of them - Sytematic Training of Effective Parenting - and perhaps again a talk by one of these people on the basics of what they're teaching mothers or what's available.

The value of experiential learning was noted by one of the graduands.

... I think that I learnt a lot subsequent from breastfeeding my own babies.

b) holistic care

One graduand described an encounter with a client in which she demonstrated **holistic care.**

I saw a patient two weeks ago and she was very tearful. I asked her what was the matter. She said she was having problems at home. I asked her what kind of problems? She said her mother shouts at her. On delving further, I discovered she was studying part-time. She had to walk to class - it was quite a walk - half an hour to 45 minutes walk to a class once a week. She didn't want to go anymore. After a while I said you know your mother's probably right. The only way to improve yourself is to study further. .... I saw her again today and asked her how she feels. She said much better - she's going to classes, she's enjoying the walk and she's much happier. I said think of it as special time with your baby and the exercise is good for you and the baby.

The graduands perceive midwifery to be a normal healthy process which should be seen as holistic, but feel that in the hospital learning environment it is treated as a disease.

I don't view midwifery as a disease process. For example we don't treat the PIH (pregnancy induced hypertension) only. It is a healthy process and should be seen as holistic.

In practice though, especially in labour ward where patients all have drips, CTG machines and are confined to bed, this is not happening. I feel that it is treated as a disease.

One graduand implied that holistic care is not adequately taught.

... we must be taught how to include other things in our education. Like everything we just focus on the mother. We forget about the father, we must learn to involve him in things.

Holistic care could be extended to the understanding of alternative health practices.

...I have certainly found that in midwifery there's a lot of place for homeopathic medicine and alternatives in daily care. It's something I feel could be included in the curriculum.

c) becoming a registered midwife

The importance of experiential learning was referred to when one becomes a registered midwife.

... any student, once you become qualified, that's the time you actually start learning.

5.4.1.1.4.2 B. Culture

a) communication and language

The need to be able to communicate more effectively with the client was verbalised.

We need to add a language - like Zulu. It would make it easier. ... If we could at least speak one of the languages, they would at least respect us and see that we're trying to get across to them.

b) care and sensitivity

Culture sensitive care was referred to in the following statements:

An Indian woman ... what she said, she doesn't want to be seen by any male nurses or doctors, for cultural beliefs.

... some come straight from labour ward and say they want to bath baby. When we say its been bathed, they say it wasn't washed properly. Provided the baby's warm, we let them do it. We're not strict.

One graduand explained that most of the patients are from the rural areas and that some of the care givers understand the cultural practices and language of these women. When the practice is harmful, the care giver may have difficulty intervening because she is aware that this may be taken as an offence against the culture. This graduand had English as a second language.

However, there are also occasions when care givers from the same culture are unable to assist or to provide explanation.

We've had a few ladies who are sangomas. They start shouting and screaming, their eyes go all funny and they said they're talking to their ancestors and you can't actually manage these people. Sister ... is from that tribe and she tried talking to her, but she couldn't do anything. This woman wanted to see her ancestors, she couldn't handle the high-tech.

Graduands expressed a need to understand cultural practices. The conflict which one may experience in trying to understand another culture was also evident.

... she's not allowed to eat chicken, milk or eggs. ... I didn't know this. ... I think culture should play a big part ... we say to them eat this, you need the protein. You need it for the breast milk ... Now at the same token I've always had my children with me and I've found it very difficult to identify with mothers who leave children with granny in Natal or sister in the Transkei because they're working - but that again is a cultural thing that I would really have to spend time learning.

The ability to discern between harmful and nonharmful health practices was recognized as a need. This was another area in which conflict was mentioned.

There's a lot of conflict whenever you try to give health education and in a specific case you try to get HIV consent. She says "I won't sign because I have no HIV, I've been to a sangoma and he's treated me." To try and get across is very hard because she believes she's cured. So anyway, I think

there's a lot of conflict with the sangomas. They're giving wrong information, because they're not picking up, we are. The patients are not believing us. To get it across - they really believe the sangomas.

Certainly in terms of the homeopathic things which I've seen a little bit of, there are things, like they use a powder to disinfect the cord and it makes the cord look really awful. ... but it works! You know. Ummm. Yet we (are) taught that it should be spirit(s), should be dry. But it works just as well as the spirit(s). Once you know what it is and how its being used.

... and the cord, they don't use alcohol to clean the cord. They use their own preparation or whatever, and we're teaching them to use alcohol. It's against their belief. ... it's a shock to realise you're teaching something that they (don't) want.

Issues relating to culture and communication were identified by the final year students (vide 5.3.1.2.16 p 215).

5.4.1.1.4.3 C. Relationship of theory to practice

a) correlation between theory and practice

The graduands did not appear to speak of the correlation between theory and practice as nurse educators do, i.e. placing students in the practical area at the time of theoretical instruction. They appear to speak of correlation as the understanding between theory and practical.

Tend to forget theory when get to wards ... you learn as you're going along. When you've learnt it in theory, its totally different when you've got to put it into practice. I mean I could never understand about (the) jaundice, okay, until I was dealing with babies in the phototherapy unit.

... but the thing is what happens in the ward and what happens in theory, just doesn't correlate, ... Even now when I know those things why, I knew everything - you've learnt it, but you haven't done it, so its difficult to actually do it. That's why I had difficulty in labour ward on the practical side. Knew what was wrong - all the abnormalities and all the rest of it but to actually do something was difficult. Obviously it takes practice, you can't be expected to, you know, do it the first time.

The latter graduand appears to be identifying a need for opportunity to practise. Another graduand highlighted the need to practise as follows:

One thing is definite, if you know your theory, you definitely go through with your practice. They do relate a lot, but you must know your theory, and practice at the same time.

b) integration of subject matter

In discussing the integration of subject matter the graduands identified the lack of lateral thinking and the need to be helped to understand the relevance of the various subjects to one another.

..., we started off with the ante-natal booking. The correlating between what we learnt and actually doing the booking, its not actually connected at all. It's rewording, what I learnt, I don't know, I couldn't apply 100% to booking in a patient, getting a history from a patient. ... What we learnt wasn't enough to go into depth - I think also because we're not taught to bring everything together - midwifery, physiology - bringing it all together. ... You know it when doing it, but it doesn't all come together. It's all separate things.

Why is it important to know that somebody has had rheumatic fever?

c) awareness of actions

It was felt that if students could be made more aware of their actions it would help to put theory into practice.

... one of the things that I've been trying to do is make them think about what they're doing. Why are they doing this? How does it relate to what we learnt? I don't know if that in the long run will help put theory into practice.

d) practical learning opportunities

Practical learning opportunities were identified and varied from input from other groups to time in a unit to additional learning experiences.

So in fact it may be quite useful in one's training then to have exposure to these people. To have a talk by a sangoma.

... But we're always blaming sangomas because we don't know what they

do. We need to know what he does, ... Maybe if they stayed in a specific area for two weeks at a time instead of just a few days.

I don't think that understanding is the problem. The issue is practice. I think that what would help is to do fifteen deliveries. If after that we could have two assessments and then do say three deliveries that we could control or conduct ourselves, this would help.

The graduands expressed a need for greater emphasis on holistic care.

We forget about the father, we must learn how to involve him in things ... or the other siblings. But we tend to focus on the mother. We don't know how to communicate with him.

5.4.1.1.4.4. D Health Promotion

a) appropriate information

In identifying that health information given to clients is not always appropriate two issues appeared to be relevant, viz. facilities the client would have available to her at home and financial considerations.

Some of what we teach is obsolete. I don't think we should be teaching, like the bidet - they don't have a bidet (at home). We should be teaching about basic hygiene education and bathing. Got to teach according to where they are. Even baby baths, they don't always have a sink. They can use a basin or whatever.

Can I expect this mother to eat prunes which are expensive for her, when she barely comes out on her money? Okay. Isn't there some other way that I can help her? ... students ... teach the mothers to use cotton wool to wash the face, cotton wool to wipe the bum. Cotton wool is expensive. So we should be teaching the mothers in the hospital to use a face cloth. She needs to buy two face cloths for her whole baby's life.

In addition, it was felt that *'we often teach from a medical perspective.'*

b) client involvement in information giving

One graduand highlighted the need to involve the client in the information giving session. She

felt that women are pressurised to breast feed, but from a cultural perspective many African women prefer to breast and bottle feed. She felt that if the care giver was not aware of this then incomplete information was given because the woman went home without information on how to care for the bottles and how to prepare formula feeds.

> *They go home and they don't know how to care for the bottles. We were promoting breastfeeding without considering culture. Most African women like to bottle and breast feed- they don't like to just breast-feed. Okay. So they go home and give bottle and the breast, but they don't know how to look after the bottles.*
>
> *I think that really depends on the mothers decision, if she wants to breast feed or not. You find you spend most of the time teaching them, whereas she doesn't have any interest at all, she wants to bottle feed.*

In involving a client in information giving another graduand felt that care givers do not take sufficient trouble to determine the woman's existing knowledge.

> *... a mother comes and we ask her whether she wants to breast feed and she says no. We accept her no, instead of saying why not?, what do you know about it?, these are reasons one should breast feed, go home and think about it, the decision is yours. Because very often they don't even know that much.*
>
> *...Or sometimes we don't realise that a mother's actually had five children and knows what she's doing and that we don't need to give her all the basic information.*

The need for information giving to be culture sensitive was evident in the following statement.

> *Part of this is in sterilization, when having a Caesar. You explain to her about it and they say no they must speak to the husband. He says no and you know that she'll be back. You sit and talk to the husband - they're not interested.*

The need to be culture sensitive may be blurred by the problems inherent in language and communication and lack of understanding on the woman's part.

I'm still finding that many mothers at six weeks check-up don't understand about keeping the baby breastfeeding to stop milk drying up. Or you ask them when they're pregnant how did the previous pregnancy go. Milk dried up, baby didn't want it. It's hard to try and explain.

c) actions of care givers

The fact that care givers may confuse the woman through her actions was described in the following statement.

> *... when all else fails, we go and get a bottle and give it to the mother. So like, we give a bottle when all else fails, so what about this poor mother who goes home, baby is not settling and she doesn't know what to do and so she gives a bottle.*

These findings are consistent with the final year students perceptions of health promotion (vide 5.3.1.2.17 p 216).

5.4.1.1.4.5 E. Graduands perceptions of the current students

a) qualities of the students

When it came to length of time spent in a unit, it was felt that the more important quality was interest.

> *If she doesn't have the interest then she will still leave that place not knowing.*

The current students are perceived as anxious about getting their requirements. It was also felt that the students may be leaving everything to the last.

> *When they come they're concerned about getting their palpations. They're in a rush, they just want to get them done. ... they're in a state because they've got to get everything.*

> *So I think each student they're going to have to make sure that within those two weeks they get everything and not just say "Oh, I've got time. Still got next year."*

b) level of knowledge

The current students level of knowledge was perceived to be above average level of some staff members.

> *I've also noticed when we give in service, a lot of the permanent staff is actually amazed by the nurses, because they ask questions that are very ... high level and some of the staff don't know what they're talking about. Ummm, so they've actually got the staff thinking about things. ... It was high level things they were asking about.*

c) learning needs

Learning needs that were identified were the need to be able to cope with conflict and to be assertive.

> *But I think that students also need some sort of training in how to deal with conflict and in assertiveness. There are high stress levels and conflict in dealing with the patients everyday in clinic. It is also made worse by the number of patients that we have to turn away.*

For the final year students stress appeared to be related to coping with the poor attitudes they experienced from the staff (vide 5.3.1.2.3 p 209) in comparison to stress related to patient care.

5.4.1.1.4.6 F Health Services

a) need to be culture sensitive

The regulations imposed by the health service are perceived to be inconsiderate of cultural beliefs and needs.

> *Just that I've noticed that some husbands or partners will come and say "No I don't want to see the baby." So instead we insist. The system says that he must see his baby but according to his culture he's maybe not allowed to see the baby in the first ten days.*

The regulations may create conflict and there is evidence that greater flexibility is needed.

This also applies to the Moslem patients when they are saying a prayer. A priest comes to whisper a prayer into the baby's ear. This brings good luck to the baby. Usually staff refuse to allow non fathers into the nursery. This causes conflict.

Other issues that related to the health structure and which created conflict for the midwife were the follow-up and referral of patients and the screening of partners.

... There is a high rate of congenital syphilis in babies. Partners refuse to be treated. It makes the treatment of mothers pointless. I feel that we need to involve the partners more and encourage them to attend clinic with their girlfriends or wives. There needs to be more interaction between nurses, patient and family. Also, follow up and treatment with HIV positive patients. Appointments to follow up now (June) are being given for December. There is no support for patients and patients abscond. ... She goes back to the community, she doesn't let anyone know, or she doesn't take any precautions. There's no one there to support her, to help her deal with it. There's nothing there for her.

b) alternative health practices

The graduands voiced a need to have greater understanding of the approaches used by alternative health practitioners and expressed the opinion that they should be integrated into the traditional health care system.

So in fact it may be quite useful in one's training then to have exposure to these people. To have a talk by a sangoma.

Its also important to know about other things - reflexology or acupuncture. These other things, it would also be interesting to know. Patients not interested in medication, what other things she can use.

There may well be very positive points in what he's telling a mother. Umm. You mentioned oral rehydration, but let's say cord care. Maybe the way that he's teaching the mothers to do cord care is in fact as effective as putting spirits on it. Perhaps the medicine he's using ... and you may be able to say to the Mom "if this is how you were doing it, its acceptable, I know about it."

... There was the story of the woman who wouldn't look at her baby,

wouldn't have anything to do with her baby. Finally, it came out that she'd seen a traditional healer during her pregnancy and this person had told her she had a monster inside her tummy. So she didn't want to look at this monster, she didn't want to have anything to do with this monster and in fact the only way they got around it was to get another traditional healer to come and convince her that it wasn't a monster, it was a baby. She refused to breast feed, to touch it. So they have a very powerful influence.

c) provision of obstetric care

In discussing the provision of obstetric care the graduands felt that it is high tech which results in a high Caesarian Section rate. It was felt that the technology increased the patients fear and this in turn influenced her pain and the numbers of complications seen. In addition, they perceive the staff as being too dependant on technology. This discussion suggests that this is not a favourable learning environment for normal midwifery and labour. These findings are consistent with the final year students who identified the lack of sophisticated technology in the peri-urban hospital as being beneficial to developing clinical skills (vide 5.3.1.2.10.3 p 214).

... staff don't want to be taken out of their normal areas, it seems that they may be scared to do care normally. They depend too much on technology and the machines. ... This increases the need for assisted deliveries and Caesars. Patients are also more afraid when they are surrounded by all the equipment.

... and fear increases the pain of labour and the complications.

Another factor which was felt to influence the provision of obstetric care was the patient load.

I also feel that especially in our situation in clinic, there's no time to spend with patients. It's all rush, rush. If the patient is in the cubicle she's scared to ask the doctor questions as he asks you to bring the next patient in. You never have time to sit and talk to her ana that puts up a barrier. If she's got a question, she's too scared to ask the doctor and you end up having to do your best. But I think we should be trained to encourage open communication.

5.4.1.1.5 Discussion of findings

Perceptions of the course by the graduands fall into two categories, viz. the theoretical component and the practical component. In the theoretical component it appears that they would have liked more emphasis and discussion on the meanings and influences of cultural beliefs and values, breastfeeding and parenting. There also appears to be a need to be better equipped to deal with conflict and to be more assertive. In the practical component it would appear that they do not perceive care as holistic. Here again the influence of culture is an issue. This is not only an issue at an individual level but also at an organizational level. The application of theory to practice needs be reinforced in the practical situations. The education of patients and the giving of information is seen to be inadequate for two reasons. Information given is often above the patient's level of understanding and insufficient time is given to this aspect of patient care. The graduands perceive the current students to be very concerned about obtaining practical requirements. Their comments about the provision of obstetric care suggest that this is not an ideal learning environment for students.

The responses of the final year students confirmed some of the points made by the graduands. The students suggested that they have more practical demonstrations before starting in practice more discussion about cultural beliefs and practices. One student felt that she would have liked more information about parenting and how a mother copes after six weeks. Perceptions about holistic care, the use of technology and information giving were confirmed. Student responses confirmed that the meeting of practical requirements does cause them stress and anxiety. (Vide 5.3.1.2.6.1, 5.3.1.2.16, 5.3.1.2.5, 5.3.1.2.10.3 and 5.3.1.2.7 pp 211, 215, 210, 214 and 211 respectively.)

5.4.1.2 FOCUS GROUPS HELD WITH NURSING SUPERVISORS

The first focus group held with the supervisors comprised of six supervisors. Two were nursing service managers, two were chief professional nurses and two were senior professional nurses. The climate was relaxed and there were no uneasy silences during the discussion.

Impressions of the group: The researcher once again tended to participate too much in the discussions. The discussion tended to be dominated by the more senior supervisors with one of the senior professional nurses hardly participating, despite efforts to draw her into the group. This was later recognised as a cultural manifestation in which some groups do not speak in front of seniors or those in authority. Again the researcher did not probe certain issues sufficiently.

A second focus group was organised. The questions for this group were planned around the issues raised in the first group. Eight supervisors were invited to this group, but three of the senior supervisors were unable to attend for various reasons. The group finally comprised of four unit managers and one dep' y. All hold a senior professional nurse position. Thus it was a homogenous group. Two were from antenatal clinic, two from the postnatal wards and one from labour ward. One person tended to dominate the conversation and one person in particular tended to interrupt others or to speak with others. This made transcription difficult.

Impressions of the group: The researcher felt that a lot had been said but there had been a good deal of speaker interruption and consequently viewpoints may well have been lost. While conversation flowed easily, there appeared to be a lack of depth. The researcher felt that there was also confusion about the group of students being discussed, as there was reference to the diploma students. At times viewpoints were contradictory. However, the more disturbing impression was that while the student's practical opportunities are perceived to be fragmented, the care given in the units is fragmented and described in task orientated terms. The lack of empowerment became clear in the issue discussed which related to the prescription of iron supplement medication. The researcher was left with the impression that the supervisors are frustrated and lack job satisfaction. These impressions are consistent with the findings obtained in the questionnaire given to the registered midwives (vide 5.2.2.8.1 p 193).

In spite of the concerns which the discussion raised in the researcher, the group was a success

in terms of the participation of the members. Because of the homogeneity of the group all spoke freely and there was discourse between the members.

5.4.1.2.1 Questions which were developed from the first focus group

Questions which were developed from the first focus group related to the following issues:

- the curriculum and practical learning experiences
- how a student's practical learning exposure differs from what she has to encounter as a registered midwife
- holistic care in practical learning opportunities
- internship
- teaching concepts such as decision making and responsibility

After the researcher had transcribed the interviews she gave the transcripts to a member of the group who agreed that they were an accurate reflection of the discussions.

5.4.1.2.2 Analysis and findings of the focus groups

The raw data were analysed using the same process as described in the previous focus groups (5.1.2.3 p 154 and 4.5 p 119).Some examples of the words and phrases that were highlighted and from which the categories and sub-categories emerged were: requirements, care and holistic care, expectations, phrases that described the clinical environment and opinions or views regarding the current curriculum.

5.4.1.2.3 Categories and sub-categories

The categories and sub-categories which emerged from this analysis of the focus groups are as follows:

A. Learning Environment

a) learning opportunities

b) practical situation

c) suggestions

B. Perceptions of students

a) part of the work force

b) personal qualities

c) requirements

d) expectations of students

C. Perceptions of newly qualified midwife

a) abilities

b) needs

D. Holistic care

a) perceptions of holistic care

b) student exposure to holistic care

E. Need for empowerment in the supervisors

The following is a description of these categories and sub-categories.

5.4.1.2.3.1 A. Learning Environment

a) learning opportunities

The learning opportunities were described in relation to student accompaniment, time constraints and learning requirements. It was felt that learning opportunities do not generate confidence in the student.

> *..., the clinical exposure of the student is different to what you have to cope with when you're registered. I certainly know in antenatal clinic we're inclined to always accompany the students. And never leave them alone. So they're actually not exposed to ...to what you're exposed to as a registered midwife.*

..., we are accompanying them all the time. ... they're only there for a week and the time is limited. They don't feel competent, that they need, within that week. You find that when they come back the second time round they're a lot more relaxed and a lot more receptive towards the education and learning they're given.

Fragmentation of clinical practice is the biggest problem. One day a week in third year is not enough. It destroys confidence and (they) have to start from scratch with her each time.

In that week all they're worrying about is getting their requirements, their palpations or whatever. ... Its not just their requirements. Because once they've got their requirements, ... they want you to do suddenly the NST assessment and the palpation assessment and everything else. ... They're not getting out of it. Its purely and simply getting their requirements.

The number of clinical requirements was felt to be adequate, i.e. fifty palpations and fifteen deliveries. However, the time allowed to obtain these was felt to be the problem.
These findings are consistent with the views expressed by the final year students who expressed the stress they had felt in meeting their practical requirements. The students felt that these should be given greater emphasis in the third year of study and felt that the registered staff were not helpful in assisting them to meet these requirements (vide 5.3.1.2.7 p 211).

b) practical situation

The practical situation described the hospital environment.

... it's crisis management, or rather with it being crisis management, the trained staff are running around and you just get rid of the student as quickly as possible. You haven't got hands and time to teach, so its slap dash because you haven't got the time.

... but then my problem with these students is that just it have changed now with the work load. But before, ..., at least you used to sit down with the students, because, even with your patient you used to relate, the relationship was very excellent with your patient because you used to know your patient. Pause. And then now you don't have time for the patient, you don't have time for the student.

Postnatal care is limited because the patients who have had a normal delivery are discharged

from six hours post-delivery and sometimes straight from labour ward. This was of concern to the researcher as it means that the students' opportunity to care for the postnatal woman and her baby is limited. The supervisors from the postnatal ward felt that this was not a problem, as Caesar patients and jaundiced babies are kept for longer periods. However, it must be remembered that these are not "normal" patients requiring "normal postnatal care." For these patients care is modified according to their special needs. Students are also exposed to the patients who are being discharged early, *"because there is a lot of health education in those cubicles."*

The students currently gain some clinical experience in a peri-urban hospital and at an urban primary health care centre. This experience is not perceived to be of much benefit to the students. In gaining midwifery clinical experience the supervisors were of the opinion that it should be hospital based. ... *don't place them in the satellite clinic. They must be inside hospitals.*

This finding is contrary to the views expressed by the students (vide 5.3.1.2.10.2 p 214 and 5.3.1.2.10.3 p 214). Students describe these learning opportunities in positive terms and their responses reveal that they do make use of these opportunities to obtain their requirements. The supervisors perceptions that the students are mainly concerned with obtaining their requirements is confirmed in the responses of the final year students. The students' responses reveal the stress in meeting requirements and the lack of support they perceive from the registered midwives to obtain these requirements.

If students are to gain experience in a midwifery obstetric unit, it appears that the supervisors would still want them to have the existing amount of time in the hospital setting. One supervisor expected them to have more time in the hospital if they were going into a community setting.

c) suggestions

Suggestions which were made to improve the students' learning opportunities related to more time in the given clinical area, that clinical placements should be sequential from antenatal to labour to postnatal, less emphasis on requirements and assessments and specific allocation for the learning of management skills and decision making. It was also felt that students should only be allowed to write up a certain amount of their requirements in a specified time, in order to prevent them from getting all in a short time span, whereafter it was felt that they then lost interest.

> *..., they should be allowed to suture first degree tears, second degree tears - not just wait for the episiotomy, of which its difficult and then one episiotomy is not enough to make a good midwife.*
>
> *Its better if she start in like antenatal or labour ward, then she comes to postnatal because once they're in postnatal ward then they don't know what is going on in antenatal and labour ward.*
>
> *The problem is you can't predict that she will get her requirements within a certain time. Otherwise you wouldn't let her write down the first two or three deliveries. ... Until now you're sure what she is doing.*
>
> *I just find that students seem to live ... live for requirements. Really that register and requirements.*
>
> *... take that student with the charge sister for a day or two and allow them to be involved in what you're doing in decision making, sorting out problems, that sort of thing.*

Allowing students to make decisions appeared to be problematic in labour ward, while in antenatal clinic it is limited to patient care.

> *... in labour ward you never get time to, ..., like the charge sister for that particular day, like you'd be allocated with the student nurse,..., allocating students, you know, doing all those things. You never get time to do that.*
>
> *..., in antenatal, its mostly pertaining to patient care, ... Over and above patient care, solving other related problems within the department you don't get a chance to do that.*

The use of preceptors in the clinical situations appears to be viewed as essential by some and with critical regard by others.

> *Preceptors or mentors are accepted, so long as that person's got her two little feet on the ground - and realises she's not there to criticise care and walk around and say this hasn't been done and that hasn't been done and don't realise that maybe there just hasn't been hands all the time to do what hasn't been done.*
>
> *...(what) will help with solving this problem is just that if we can have a person, a clinical sister, that will be allocated to the student nurse - either in labour ward or antenatal, but somebody must help the student, that is to follow the student ...*

The participants were probed as to what they understood by "learning environment" and "student accompaniment". Student accompaniment was described in terms of supervision, guidance and giving advice. It was felt that because students do not always know what is expected of them, they should not be left to function alone, but should always have a trained person with them. The trained person should be teaching and giving support.

In describing a learning environment it was felt that a student learns best when she is supported and when she is not stressed. This should be borne in mind by the trained staff who should work at creating an environment conducive to learning. It was felt that this could be achieved through good communication, orientation and the use of teaching aids. It was also felt that the learning environment should give the students opportunity to ask questions and to verbalise problems in learning.

The final year students (vide 5.3.1.2.6.1 p 211) felt that their practical supervision could be improved by the use of tutors who could visit frequently.

5.4.1.2.3.2 B. Perceptions of students

a) part of the work force

There was no doubt that students are seen as the work force.

Students are very much part of the work force, they are not a student force.

We could use them where we use the registered midwives.

b) personal qualities

The students were generally viewed in a positive light. They were described as *'keen.'* However, it was also noted that there are some who are not interested in midwifery and who are only there to obtain their requirements. This was mentioned as a comparison of the four year course, where midwifery is integrated into the course, as compared to the single registration.

c) requirements

It was also perceived that students could not always focus only on the their current learning opportunities because they were having to complete assignments for the other nursing disciplines as well.

> *...while they're busy with midwifery they're busy doing assignments for psychi and everything else. ... So you've got [illegible] of that on their minds as well, which also makes it difficult.*

It was also felt that midwifery required a more mature person and that therefore it should be taught in the latter years of the course.

Again the practical requirements appeared to be an issue. If the student still needed to obtain requirements it appears to be her main concern and when she has obtained them she appears to loose interest in her work.

> *I just find that, that ... that's what they seem to concentrate on (their requirements). They don't relax and enjoy what they're doing, because they've got to meet those requirements.*

d) expectations of students

Some of the statements made revealed unrealistic expectations of the student. Students who

have been out of general nursing for a while because of clinical placements in midwifery and psychiatric nursing sometimes express apprehension about going back into the general wards. This is aggravated by the realisation that they are more senior and the expectations of them from the registered staff is greater. This was reflected in the following statement:

> *... and when they go back they're more senior, somehow you forget they haven't been there for awhile, you expect them to meet that very sick patient's more senior needs.*

The question of competency appears to be viewed in unrealistic terms.

> *They don't feel competent, that they need (to develop), within that week.*

> *You know I just find it strange that if we get a new sister in antenatal clinic, it can take me up to four months to fully orientate her to all the areas in antenatal clinic, yet a student, within a week we expect her to be orientated and be familiar with all the areas in antenatal clinic.*

The use of the students as work force was confirmed in the responses of the final year students (vide 5.3.1.2.6.1 p 211). One student stated that staff need to realise that we are in the wards to learn.

5.4.1.2.3.3 C. Perceptions and needs of the newly qualified midwife

a) abilities

The newly qualified nurse is not seen as ready to take on her responsibilities. They were described as *nervous* and appeared to be reduced to the status of a student in labour ward. She is given a patient with another student and together they work under the supervision of another registered midwife.

b) needs

In all areas, i.e. antenatal clinic, labour ward and postnatal wards, an informal type of internship is given.

...it can take us four to six months to orientate a person into clinic. And it can take another good six months on to that before they're allowed to look after their own patients. ... they are totally familiarised with each area .... And not just learning how to do a booking ...(but) to look at the patient's needs and not just to fill in. ... We give them a month or so in each area .... and not by themselves, and only then will they be moved into midwives clinic. And they will work with a midwife before they are given responsibility of their own patients.

Labour ward provided a three month period which they regarded as a *'training period'* and the postnatal wards also gave them a student status. The newly registered midwife is orientated as a student, she works with a student and is supervised by the registered midwife.

In the postnatal wards the newly registered midwife is not allowed to "run a shift" or do night duty for the first six months. This appears to be contradictory because it is not unusual for student midwives to be alone on night duty and it does happen that they may be left in charge from 16:00 and 19:00. It is disconcerting to see that after four years of study the newly qualified midwife is still being treated as a student.

There was discussion as to whether the informal internship should be formalised. All the participants felt that there should be a formal period of internship. However, some of the suggestions were unrealistic in that six months was suggested in each area. When this was pointed out, it was realised that one would have to consider internship in the other nursing disciplines as well. There was also discussion as to whether this should be pre or post registration with the Council or whether it should be pre or post the final examinations. Whatever approach was adopted it would result in an extended period of training and the course is already four years. It appeared that the main concern was newly registered midwives who went into private practice without any post registration experience. It was felt that the Council should control this, "so that they can't open their own practice without a certain amount of practice in an internship."

In contrast to the views of the supervisors, the final year students felt competent as beginning

midwifery practitioners (vide 5.3.1.2.12 p 215).

5.4.1.2.3.4 D. Holistic care

a) perceptions of holistic care

Some of the statements which reflected the supervisors understanding of holistic care are:

> *Holistic care is you know, is the family and the baby and the surroundings, I think.*
>
> *... its not holistic care because its fragmented. ... you know that its postnatal and then back to antenatal and then back to labour ward.*

b) students exposure to holistic care

It appears that perceptions of whether students experience holistic care differ.

> *But I also think if we can go back to, its because again we get down to requirements - all they can see is an abdomen and palpation. Pause. That's all they are concentrating on ... they're not concentrating on the fact that the patient has a personality and has a family life and could be having problems and that sort of thing as well.*
>
> *It's partly role-modelled, but at the same time the work load ... I do, I think in clinic they get the holistic care, certainly from the midwives, but when they get into working with the doctors they don't. They don't see holistic care.*
>
> *... clinic is very multi-fragmented ...*

It is perceived that students experience holistic care between first, second and third stages of labour, but that once the student has delivered the patient she looses interest. There was some discussion as to whether too much care is delegated to a support person during the first stage of labour - *"so it means in this case it's not the student that is giving - uhhh,support to the patient, it is the relatives - the husband or whoever."* However, it was stated that *"the student is always there with the patient."* The provision of holistic care does present problems in labour ward when students are needing deliveries - *" ... she's the one who is needing delivery.*

Leave the patient and move to the next patient."

The format and nature of the students clinical assessment is perceived detracting from holistic care.

> *One other thing is their assessment criteria. Umm, especially from the ..., cause now it doesn't talk about any other aspect except the palpation itself. ... and then one does one assessment to assess them on palpation only. But I mean you've got to see the patient as a patient walks in - that's when you start assessing the patient.*

Suggestions to increase the students opportunities to experience holistic care were that students should visit the patients who they had delivered in the postnatal wards and that practical should be sequential, i.e. antenatal, labour, postnatal, *'to build relationships.'*

The above statements, which are frequently contradictory, reveal a lack of understanding of the concept of holistic care. The final year students responses imply that they did not experience holistic care being given at the main academic hospital. One student in describing the learning environment at Carltonville Hospital stated that *"care is seen in its totality as the woman is with the same staff from admission to discharge."* Another stated that holistic care was seen at the Alexandra Health Centre. (Vide 5.3.1.2.10.2 and 5.3.1.2.10.3 p 214).

5.4.1.2.3.5 E. Need for empowerment in the supervisors

During the discussion it became evident that the supervisors are unable to problem solve and to confront. There was a discussion regarding the administration of iron supplements and vitamins to post-natal women. The researcher suggested that the supervisors of this area needed to request a meeting with the area supervisor and develop a policy. The supervisors admitted that this was necessary because *"at the end of the day she (the patient) goes home without pregamal because it was not written up by the doctor."*

5.4.1.2.4 Discussion of findings

The learning environment is not ideal for the students. One supervisor emphasised three times

that the students are not left alone and that they always work with a registered midwife. This was because they did not feel confident to leave her to work alone unless she had proved herself and they could trust her. This means that the student does not have opportunity to learn to work independently or practise decision making skills. The lack of opportunity to work independently was highlighted in the final year students responses (vide 5.3.1.2.10.1 p 213). For the students the difference between the learning environments of the various settings used was the opportunity to work independently and yet feel secure to know that they were being supervised and that they could ask for help. From the findings of the focus groups held with the supervisors the antenatal clinic appears to allow the students little or no independent practice. However, this area is viewed in a positive light by the students. It is seen as a positive learning environment. It is described as an area where teaching occurs, where there is supervision and guidance and the emotional climate is positive. These findings appear to support Watson's views (Magnussen and Trotter 1997). She states that nursing education has failed in two significant ways - firstly, we have failed to address the issue of how to educate and secondly, we have continued to focus on how to prepare students to be institutional employees. O'Neill and Duhy (1997:825) state that "... it seems more likely that the knowledge needed for clinical diagnosis is mentally organized quite differently from that used in critical thinking." They go on to say that diagnostic reasoning depends on specific knowledge of the person, treatment options and patient responses. It is streamlining knowledge and information to obtain a single label. This may explain the students responses to their perceptions of the antenatal clinic.

The supervisors do not appear to be familiar with the curriculum and in particular appear to fail to understand the aims and objectives of the four year curriculum. These findings are in contrast to the views expressed in the questionnaire given to the registered midwives in which the majority (59,4%) felt that they had knowledge of the curriculum (vide 5.2.2.9 p 195). The supervisors have not considered the implications of the change in the health care system to that of a primary health care approach for midwifery education. It is difficult to deduce from these findings whether it is a reluctance on their part to move with the changes in the four year curriculum or whether they have become so enmeshed in hospital practice that they have not

taken cognisance of the broader implications of changes in the health care system other than those which have had a more direct effect on their practice, e.g. the making of antenatal and delivery services free to all women. Mc Millan (1992) quotes Andersen as having found that "... nurses did not use information, and neither were they in a position to generate information." The need for community based midwifery experience does appear to be seen as an essential factor in preparing midwives for future practice.

The lack of understanding of student needs is reflected in the responses of the final year students (vide 5.3.1.2.6.1 p 211). The students' responses reveal a lack of willingness on the part of the registered midwife to help in the acquisition of their practical requirements. Their responses confirm the need for staff to know more about the objectives of their course and their practical requirements.

The learning environment is not conducive to teaching students to be critical thinkers. This requires a trusting environment. The supervisors acknowledged that the students always work with a registered midwife until they could trust her and agree to let her be exposed to work on her own.

The nursing supervisors perceptions and guidance of the newly qualified midwife is disturbing. After four years of study and practical experience she appears to be treated more as a student than a beginning practitioner. O'Neill and Dluhy (1997:828) identify three levels of professional development, viz. the undergraduate student, the beginning clinician and the experienced clinician. They describe the stage of the beginning clinician as encompassing approximately three years. They go on to say that it is during this time that she develops understanding about the practical manifestation of responses to situations and her reasoning moves away from rigid rules to a more "... analytical pattern of rational, deliberate thinking." It is during this period that the practitioner becomes aware of the limitations in her thinking. When viewed in this light, it can be argued that the practitioner's professional development is being retarded in the study environment or that too much is expected of her.
The findings of this study are consistent with those of Madjar et al (1997:vii) who report that

experienced nurse, including nurse managers, tend to have very traditional expectations of new nursing graduates. They suggest that the newly qualified practitioner may require a period of clinical practice in which to develop complex skills. Also consistent with this study was the finding that registered nurses do not believe the duration of clinical placement for students to be sufficient. They go on to say (1997:viii) "they are also critical of the organisation of such experiences so that students are not given a realistic understanding of the nature of nursing work." Consistent with the views expressed by the antenatal clinic staff, in particular are their findings that "...,experienced registered nurses expect that new graduates will require a great deal of assistance and guidance in mastering both the technical and the psychosocial skills needed to engage in nursing practice, ..."

5.5 PART B - THE DEVELOPMENT OF THE PROBLEM-BASED CURRICULUM

During the workshop the facilitator asked the staff to consider the present four year undergraduate curriculum. Each staff member was asked to describe how she perceived the current situation. A summary of these perceptions will be presented.

5.5.1 SUMMARY OF STAFF'S PERCEPTIONS OF THE CURRENT CURRICULUM

Constraints in the present paradigm were identified as being:

Firstly, the South African Nursing Council which controls the education of nurses and which is the registering body.

Secondly, the Department of Education which approves degrees. Approval considers the number of courses offered in the degree. In addition, a professional degree is required to meet requirements in terms of balance of basic sciences to professional subjects.

Thirdly, the status of the nursing department within the University, itself. The nursing department is in the then Faculty of Medicine. In 1995 it became the Faculty of Health

Sciences and a change in attitude is apparent more recently. However, at the time of this focus group the Faculty of Medicine could be described as egocentric and steeped in tradition. There is a strong emphasis on the natural sciences, on curative and hence hospital based care and on specialisation. The nursing department is a small department and experiences financial constraints and a heavy workload related to students theoretical and practical needs. As a result research and publication have suffered and this has further resulted in loss of credibility in the faculty.

Fourthly, the type of student entering the programme needed a considerable amount of assistance. The quality of her schooling was not seen as preparing her for university education. The students receive a salary from the hospital authorities where they hold student posts. This makes them a member of the work force and they are obliged to conform to certain requirements. This means that the students are not students in the true sense of the word. Furthermore, the philosophy of the employing authority is that care is hospital based rather than preventive and promotive.

Fifthly, the approach to curriculum development adopts a layered approach and again is very traditional.

Based on these constraints, problems with the present paradigm were identified. These could be grouped into four main areas, viz. community, the medical model, curriculum and cultural issues.

In relation to the **community**, it was felt that the health needs of the community were not being met, because of the emphasis put on the curative aspects. In this regard, it was felt that there was evidence to suggest that the community was not satisfied with the care being given.

The use of the **medical model** meant that the focus was community-oriented, rather than community-based and that students were not gaining an understanding of health factors. Care

in this model is directed towards the individual, with little attention being given to the family and the community. Furthermore, insufficient attention is given to holistic care.

The current **curriculum** was felt to be stifling creativity and to be making limited use of experiential learning. It did not encourage problem solving and the discovery of knowledge. Despite the repetition and overlap of content between courses, lateral thinking did not appear to be being developed.

The emphasis which was given to the curative in the curriculum, placed a heavy demand on the resources and the services. In addition, it was felt to be inappropriate in meeting the health needs of the community and for managing the transition period which the country was about to enter and the problems that this period would bring.

Cultural issues were identified in the lack of collegial relationships amongst the students in the classroom.

5.5.2 SUGGESTIONS FOR A 'NEW' PARADIGM

The staff were then asked to make suggestions for the "new" paradigm. Suggestions made included:

- the use of problem-based learning with greater emphasis on the community;
- a programme of care that could be shared with other health workers and other disciplines;
- a practical programme that stressed clinical competence and accountability, but that also fostered a professional capable of adapting the resources available to the given situation and who was capable of participating as an equal partner in the situation;
- student to have the knowledge, skills and understanding of community involvement in health care;
- ability to make a contribution to the health of the individual, the family and the community. This should be learnt in the community;

- the staff should facilitate this through the development of community partnerships;
- research should be facilitated by incorporating it into the community-based programme. This should include the collecting of information, identifying problems and resources. This process should act as a reciprocal to hospital based learning.

A community-based programme using problem-based learning as the teaching \ learning strategy was suggested. Further discussion considered the possibility of this suggestion. Here positive factors were identified. These included:

- access to a library, community facilities and the reputation of the university and the faculty;
- a dean of the faculty who was sympathetic to the department's needs and who was aware of the changes taking place in medical education. He was also aware of community needs in the province and the need for the faculty to meet the health needs of the local community;
- some community links were already in existence;
- the time was considered to be appropriate given the changes taking place in the country.

Given these positives it was agreed that the "new" paradigm should embrace the concepts of problem-based learning and community-based education.

The next step was to consider the structure of the problem-based curriculum. Given that the new government would adopt a primary health care approach to health care, it was agreed that a health to illness continuum should provide the foundation to the curriculum. The concepts of primary health care and community-based education called for the focus to be on the community, the family and the individual. Given the problem that was identified with regard to repetition of material, it was felt that the programme should aim at greater integration. For this reason midwifery would become more encompassing of women's health and include aspects of women's health currently taught in, for example, the nursing courses. In order to provide for the concepts of community, family and individual and focus the community-based aspects of the course it was felt that instead of having two courses - nursing and community

health nursing - one course, called comprehensive nursing, should be developed. In order to stress the emphasis of the health to illness concept, the relevance of the term "psychiatric nursing" was considered and found to be inappropriate. Thus the course was renamed "psycho-social nursing."

The broad outline of the "new" paradigm is as follows:

First year Comprehensive Nursing I.
Focus: The healthy community, family and individual.

Second year Comprehensive Nursing II
Focus: The disordered community and family and the individual with health problems.

Third year Comprehensive Nursing III
Focus: High risk groups.

Psycho-social Nursing I
Focus: Mental health

Women's Health I
Focus: The healthy woman across the lifespan.
The healthy neonate and child.

Fourth year Comprehensive Nursing IV
Focus: High Risk Groups and Comprehensive Care.
(This should include institutional and community aspects of rehabilitation.)

Psycho-social Nursing II
Focus: High risk communities, families and individuals.

Women's Health II

Focus: Women at risk across the lifespan.

The high risk neonate and the sick child.

5.5.3 IDENTIFICATION OF THEMES

The next step in the process was to agree upon the model which would be used within the problem-based approach. The medical model was rejected at the outset as it had been identified in the problems associated with the current curriculum. The bio-psycho-social model was found to be limiting for some of the areas. An experiential approach was viewed as being the most suitable app' oach to adopt, given the discussion which had evolved around the "new" paradigm (vide chapter 7 for further discussion on this approach). In order to further develop this approach, themes needed to be identified. It was decided to take a health issue and identify concepts and needs associated with the problem. Teenage pregnancy was chosen as it was felt to be a problem to which each discipline could contribute. This brainstorming exercise produced a list of concepts and associated issues. The similar issues were then clustered and appropriate names sought for each cluster. From this exercise the themes for the problem-based curriculum were developed. The themes that were identified are:

nursing

communication

teach \ learn

growth \ development

health issues and determinants

profession

health care system.

It was believed that these should be developed within a context of values, beliefs and skills. Furthermore, it was felt that certain concepts should run as threads through all the courses, e.g. lifestyle and nutrition should be threads in health determinants, transcultural nursing and legislation should be threads in profession and legislation should be a thread in health care

determinants. (For definition of themes see 7.8.2.2 in chapter 7).

The themes were validated against the themes developed for the BScN Programme offered at McMaster University and were found to be remarkably similar. Themes which have been used in this programme are:

nursing

communication

teach\learn

concepts\theories

health issues

profession

health care system.

5.6 CONCLUSION

In this chapter the findings relating to the four main concepts of the framework have been presented and discussed. The process that was followed in the development of the problem-based curriculum has been described. In the next chapter the implications of these findings for nursing education will be discussed. The discussion will be limited to the implications for the development of the courses in women's health.

CHAPTER SIX

IMPLICATIONS OF FINDINGS FOR NURSING EDUCATION.

It is in exchanging the gifts of the earth that you
shall find abundance and be satisfied.
(Gibran 1997:43)

In this chapter the implications of the findings, both from the literature and the research, will be discussed.

6.1 IMPLICATIONS FOR EDUCATION FROM THE NATIONAL AND INTERNATIONAL NURSING LITERATURE.

..erature describes the "different" nurse that is needed for the future. The cost of hospital care and the changes in the disease profiles throughout the world are going to result in greater need for community and home-based care. Nurses have essentially been prepared for hospital-based care. The literature reveals that nurses do not feel adequately prepared to render such a service. Inherent in this is the need to produce a nurse who values patient advocacy and holistic care. Thus the type of education which nurses receive will have to change and practical learning opportunities will have to become more community-based.(Vide 2.6 p 49.)

If nurses and midwives are to function adequately at this level they will be functioning as primary care-givers and therefore they will need to be capable of problem-solving and critical thinking. The traditional curriculum does not focus on the development of these skills. This means that teaching and learning strategies need to be adapted to provide for this. If teaching strategies are to be altered, then the role of the teacher needs to be redefined and "new" types of teachers need to be prepared. Problem-based learning is said to encourage critical thinking and problem-solving. It encompasses the concept of teacher-as-learner and considers the role of the teacher to be that of a facilitator of learning. A facilitator of learning stimulates learning

through the presentation of problems and challenging situations. This means that curricula need to be revised and learning material needs to be rewritten. To prepare nurses and midwives who are capable of community-based work, consideration needs to be given to the content covered in the curriculum. The knowledge explosion makes it impossible to cover everything and therefore the curriculum needs to focus on the process of learning and discovery and to include problems that are relevant to the community. Students need to be guided so that they are capable of using the information which they acquire. If they are to be able to use and apply knowledge appropriately, then consideration needs to be given to their learning needs.(Vide 2.2.2, 2.1.4.2.3, 2.2.9, 2.4.1 and 2.7.4 pp. 30, 25, 37, 42 and 59 respectively.)

The literature emphasises the need for caring and dialogue in nursing practice. A means to achieving these ends is the fostering of group work. Through group work dialogue is promoted in the group discussions and caring can be role modelled and encouraged through group support and peer teaching \ learning.(Vide 3.2 p 74)

Historically, nurses and midwives have been socialised into roles that are characteristic of disempowered individuals and groups. If they are to function at a primary care level they need to become empowered in such a way that they can foster this in their clients. It must not be at the expense and victimisation of their clients. (Vide 2.1.4.2.2 p 24)

Finally, the change in the health policy as outlined in the National Health Plan and its attention to women's health, needs to be considered. The curriculum needs to be comprehensive and to take note of women's needs across the lifespan. The tendency to focus on reproductive and contraceptive needs will not meet the objectives set out in the National Health Plan. In planning a comprehensive curriculum, cognisance needs to be taken of the primary health care approach to health care and of the community's needs. (Vide 2.6 p 49)

6.2 IMPLICATIONS FOR EDUCATION FROM THE RESEARCH

These will be discussed under the four concepts of the conceptual framework.

6.2.1 SECTION A - ENVIRONMENT

Consideration needs to be given to the statistics which reflect the health care needs of the women in this community. The impact of lifestyle on health manifested in the community women's groups therefore needs understanding. Aspects which need to be covered in the childbearing women include abortion and termination of pregnancy, normal pregnancy, labour and puerperium, breech deliveries, assisted deliveries - especially vacuum deliveries and care of the woman who has a Caesarian Section. In the first interim report on confidential enquiries into maternal deaths in South Africa (1998:26) the Department of Health states that the six primary obstetric causes of maternal death are:

- hypertensive diseases of pregnancy (20,3%),
- infections, including AIDS (18,0%),
- obstetric haemorrhage (14,2%), with antepartum haemorrhage making up 5,3% and postpartum haemorrhage 8,9% of this figure,
- early pregnancy loss (12%),
- pregnancy-related (6,8%), and
- pre-existing maternal disease, e.g. cardiac disease (10,5%).

The remaining 17,4% of causes are non-specific to obstetrics.

Aspects which need to be considered for non-pregnant women are contraception, carcinoma of the cervix, carcinoma of the breast, aging and menopause. An analysis of the most prevalent reasons for admissions to the gynaecology wards of the academic hospital revealed the following:

- emergency admissions:
    - conditions associated with pregnancy - incomplete abortion and ectopic pregnancy;
    - pelvic inflammatory disease, in some instances associated with a positive HIV,

and

- abnormal uterine bleeding, associated with fibroids or post-menopausal. Very often these women are also anaemic.

- elective admissions:
  - conditions associated with carcinoma. The carcinomas most frequently seen are of the cervix, ovary, endometrium and vulva;
  - multi-fibroid uterus, resulting in total abdomenal hysterectomy and bi-lateral salpingo-oophorectomy, and
  - sterilizations.

The staff report that HIV has altered the clinical picture of pelvic inflammatory disease. Women who are HIV negative are treated with "routine" intravenous antibiotics, e.g. streptomycin and gentamycin and are discharged after 48 hours. The women who are HIV positive are started on these same antibiotics, but usually do not respond to the treatment. They are then commenced on Rocephin (which requires drug motivation) and Clindamycin. If they do not respond to these antibiotics, they undergo a salpingectomy. These women are usually in hospital for an average of two weeks (personal communication). This picture illustrates the changing picture and cost to health care which HIV has caused. This has implications for education as students need to understand the effects of this on management of the unit, health costs - in terms of medication and patient stay and the care of a woman whose health status is far more compromised.

6.2.1.1 IMPLICATIONS DRAWN FROM THE HOSPITAL SETTING

The interviews with the patients in the hospital setting had the following implications for nursing education:

- the need for information and health promotion. This was particularly evident in that mothers did not know causes of death of their infants; there was lack of knowledge regarding danger signs of pregnancy, diet, emotional changes and breastfeeding. Women stated that it would have been easier if they had of known what to expect in labour. (vide 5.1.1.2.6 p 130)

- the need to give information in an appropriate manner is suggested by the low attendance at antenatal classes. In addition, timing of classes needs to consider the working mother. Students therefore need to learn management skills as well as some teaching / learning skills. (Vide 5.1.1.2.8 p 133)
- aspects of care which appear to be lacking relate to pain control, management of the second stage of labour, individualised care and emotional support from labour companions. This was evidenced by the small percentage (3,2%) of women who reported having been given pain relief. Only 20% of the women had had the support and comfort of a labour companion. Evidence of individualised care was mentioned by only six of the 250 women interviewed post-natally, while 32 (12,8%) described aspects which referred to management of the second stage of labour. (Vide 5.1.1.2.10 p 136)
- identification of the needs of special groups, e.g. the teenage mother, needs to be addressed in the curriculum. This was evidenced in the remark by one school going mother who related how she had been encouraged to go back to school and complete her schooling. (Vide 5.2.1.1.2.10 p 136)
- the low expectations expressed by the women demonstrate a need to empower women. This was evidenced by the large percentages of women who could only respond positively or negatively to questions which related to their expectations of care. They were unable to describe their expectations in any detail. Thus education for self-care and empowerment become important. (Vide 5.1.1.2.10 p 136)
- primary health care services need attention as women appear to be reluctant to use them. This was evidenced by the large percentage of women (79,6%) who said that they would have their subsequent babies at this hospital. These women may be implying that they view primary health care and the clinics as an inferior service. Education of the community and community participation is therefore significant.(Vide 5.1.1.2.18 p 143)

6.2.1.2 IMPLICATIONS DRAWN FROM THE COMMUNITY SETTING

From the focus group interviews the following implications were identified:

- opportunities for community-based education. This was evidenced in the womens' willingness to have students attend their meetings.
- the need for information and knowledge. This was evidenced in the references made to the requests for information relating to the action of contraceptives, for information about children's problems, as well as self. Women frequently stated "they don't tell you." (Vide 5.1.2.5 p 156)
- the concept of caring. This concept was mentioned 32 times in the four focus group interviews. Statements such as, "they (referring to the nurses) don't care", were made and suggest that this quality has to be developed and nurtured in learners. (Vide 5.1.2.5 p 156)
- communication and inter-personal relationships. The poor means of communication, with references to nurses shouting and the poor inter-personal relationships described in the nurses non-verbal communication have implications for a curriculum. (Vide 5.1.2.5 p 156)
- professionalism. Poor professional behaviour was described in terms of verbal and non-verbal communication. One woman described how epaulettes gave the nurse a superior attitude. Thus the meaning of belonging to a profession needs to be engendered and the responsibilities of being a professional need to be understood. (Vide 5.1.2.8 p 170)
- health promotion. This was evident in the women's frequent requests for knowledge as well as in the inappropriate information which women described they had been given, e.g. being told to follow a diet that was not feasible given her financial status. (Vide 5.1.2.5 p 156)
- caring environment. The need for learners to appreciate the importance of a caring environment is evident. One woman described how when she was in labour she was told that she was behaving like a child and she was left alone. Another told how when she gave a history that was of a very personal and confidential nature, the nurse called

others to come and hear what was being said. (Vide 5.1.2.5 and 5.1.2.6 pp 156 and 164 respectively)

6.2.2 SECTION B- THE REGISTERED MIDWIFE

The findings in this section have the following implications for the curriculum:

- the hospital-based midwives are not equipped to prepare students for community based practice. This was evident in the finding that 89% stated that they had gained all their experience in hospital settings, while only 4,7% had gained some clinic experience. (Vide 5.2.2.5.1 p 190)
- the lack of significance which they give to research suggests that they are not committed to critical thinking. This was seen as her least important function by 42 % of the respondents. If one wishes to prepare practitioners who are research-minded then they do not have the role-models to develop this quality. (Vide 5.2.2.8 p 193)
- poor self-image and low job satisfaction implies that they are poor role models for the students. The midwives described their lack of motivation, lack of enthusiasm and inability to function as change agents. This finding may have major implications for a nursing curriculum, as students usually enter the programme with enthusiasm and motivation. If the opposite is role-modelled to them, then attrition rates are likely to be high. (Vide 5.2.2.10 p 197)
- there is a need to reconsider aspects of caring. Midwives mentioned the patient load in relation to being able to care. It was also felt that the early discharge of newly delivered patients influenced care. (Vide 5.2.2.7 p 192)
- midwives in the clinical situation need to have a greater understanding of the curriculum and student needs. Only 45,3% of the respondents ranked this first and second in order of importance of their functions. This suggests that they do not fully appreciate student needs in terms of teaching. (Vide 5.2.2.8 p 193)

6.2.3 SECTION C - CURRICULUM

Students' perceptions regarding the curriculum have the following implications for redevelopment:

- the clinical learning environment is described in negative terms. Students used phrases such as "derogatory" remarks, " hostile environment" and "horrible experience" to describe their clinical learning opportunities. Such a learning environment is not conducive to the development of critical thinking and self-directed learning. (Vide 5.3.1.2.3 p 209)
- the need for those in the clinical areas to be aware of the needs of the student and of the curriculum. Students stated that the clinical staff should know what they were expected to achieve in terms of requirements and should know their level of study. (Vide 5.3.1.2.18 p 217)
- the need for more information relating to parenting, holistic care, ethics, communication skills, health promotion, counselling skills, social aspects of health, family care, community based care and medico-legal aspects. (Vide 5.3.1.2.5, 5.3.1.1.14 pp 210 and 207 respectively)
- a greater understanding of culture and the need to learn an African language such as Zulu or Sotho. (Vide 5.3.1.1.6 and 5.3.1.2.16 pp 202 and 216 respectively)
- student assessment and racial sensitivity needs to be considered by the faculty. Ten of thirteen students felt that race influenced assessment outcome. (Vide 5.3.1.1.9 p 203)
- need for more supervision in practice. In the initial questionnaire given to all students 48,7% felt that more supervision was needed. This was supported by the finding from the questionnaire given to the final year students, where 10 of 19 (52,6%) felt that supervision was inadequate. (Vide 5.3.1.1.13 and 5.3.1.2.6 pp 207 and 210 respectively)
- identification and awareness of student problems. Some of the problems identified by the students may be overcome if the teacher is aware of them, e.g. difficulty with subject matter and poor study methods. In a traditional curriculum these may not be easily identified. Hafler (1991) suggests that facilitators in a problem-based learning

curriculum have a better understanding and knowledge of students. (Vide 5.3.1.1.10 and 2.1.4.1 pp 205 and 18 respectively)

6.2.4 SECTION D - OUTCOME

The focus groups held with graduands and nursing supervisors highlighted the following implications:

- use of experiential learning. This was evidenced by one of the graduands reporting on how much she had learned from breast-feeding her own babies. (Vide 5.4.1.1.4.1 p 227)
- need for more information regarding breastfeeding, parenting, culture and culture sensitivity in caring. One graduand felt that it would be useful if as a new midwife, she had had more information about parenting. Information relating to culture was described in terms of diet, beliefs and values. (Vide 5.4.1.1.4.2 p 229)
- need to learn an African language. One graduand felt that even if she could speak one of the African languages, it would be seen by the patient as an attempt on her part to communicate with the patient. (Vide 5.4.1.1.4.2 p 229)
- attention to the integration of content. The relationship between theory and practice is not always evident to students. One graduand said that she tended to forget the theory when she got to the wards. She went on to say that it was totally different when she had to put it into practice. (Vide 5.4.1.1.4.3 p 231)
- health promotion and the giving of information. Graduands seemed to agree that health promotion was a neglected area in practice and that very often the information given was inappropriate. The latter aspect was mentioned in relation to diet and hygiene needs. (Vide 5.4.1.1 4.4 p 233)
- professionalism and advocacy. The need to be an advocate for the patient was described in relation to meeting patients' needs for information after being seen by a doctor. This was acknowledged in terms of her professional role, but the pressures of the clinic in terms of time and patient load created a conflict for her. (Vide 5.4.1.1.4.6 p 236)

- opportunities to learn holistic care. Graduands felt that holistic care was not adequately taught and that this could be extended to the use of alternative health practices. (Vide 5.4.1.1.4.1, 5.4.1.1.4.6 and 5.4.1.2.3.1 pp 228, 237 and 242 respectively)
- inadequacies of the clinical learning environment. This also referred to holistic care as well as to the length of time spent in clinical placements. (Vide 5.4.1.1.4.3 p 231)
- students are not given the opportunity to work independently and to make decisions. Students appear to be made to be dependent. (Vide 5.4.1.2.3.1 p 242)
- the meaning of holistic care. There appeared to be a lack of consensus among the supervisors as to what this means and in discussion it became apparent that some did not really know. (Vide 5.4.1.2.3.4 p 250)
- the lack of empowerment of the practitioners. One supervisor mentioned a problem that she had had in her unit. The discussion moved towards problem-solving in which she was given advice on how to handle the situation. During the discussion it became evident that she was disempowered and apparently had little or no ability to stand up for what she knew what right. (Vide 5.4.1.2.3.5 p 251)
- students experience poor care. This refers to the perception that students are part of the work force. In addition, it is recognised that students theoretical requirements do not allow her to focus totally on one aspect of their clinical learning. This aspect should be considered in the scheduling of assignments and projects. (Vide 5.4.1.2.3.2 p 246)

6.3 CONCLUSION

In this chapter the implications of the research for the development of a curriculum in women's health were discussed. It is clear that a number of concepts overlap and are found to be implications across the sections, e.g. caring, holistic care, the learning environment and culture. In the next chapter a curriculum for women's health will be developed.

CHAPTER SEVEN

SUGGESTED CURRICULUM FOR WOMEN'S HEALTH

But let there be no scales to weigh your unknown treasure;
And seek not the depths of your knowledge with staff or sounding line.
For self is a sea boundless and measureless.
Say not, "I have found the truth," but rather, "I have found a truth."
(Gibran 1997:62)

In this chapter a curriculum for women's health is proposed. A curriculum approach and principles on which it is developed are described. The chapter includes a description of the considerations and factors which constrain the curriculum, application of these factors in relation to a woman's health curriculum, level objectives for the programme and the philosophy, goals and learning packages for the course.

7.1 THE CURRICULUM APPROACH

The curriculum is developed on the experiential approach. The writings and views of Dewey, Schon, Vaughan and Pearson will be considered in this section.

7.1.1 DEWEY

Carl (1995) writes that Dewey is generally regarded as the father of the experiential approach. He goes on to say (1995:51) that this "... approach is subjective, personal, heuristic and transactional. It lays stress on the role of teachers and pupils and their co-operative curriculum decisions. It makes use of self-directed, unstructured and personalized instruction programmes as 'self-paces'." Essential to this approach is the use of values and experiences and the active involvement of the student is necessary in order to maximise learning outcomes. Broad objectives are used to give direction, but do not necessarily specify the ultimate aims. This approach takes cognisance of the continuous growth of the individual, as she evolves towards a more mature and complete person. The curriculum, therefore has a directive purpose, while

processing skills and affective experiences constitute the content (Carl 1995). Dewey also believed that education must concern itself with the relevant societal demands and pressures (Gwele 1996b).

For Dewey, experience is a transaction. The transaction may be a limited one or it may be a highly complicated activity, but in either case it is an additive one. It therefore follows that not all experience is equally valuable. Geiger (1958:18) quotes Dewey as saying "Oftentimes ... things are experienced but not in such a way that they are composed into *an* experience. There is distraction and dispersion; ..., we have *an* experience when the material experienced runs its course to fulfilment. Then and then only is it integrated within and demarcated in the general stream of experience from other experiences ..." It also follows then that experience is a natural phenomenon, but it is "... an affair of 'having' as well as of 'knowing'" (Geiger 1958:20). Dewey also speaks of the value of context in relation to knowledge. "Just as value emerges from a context, so knowledge comes out of a transaction that encompasses other aspects of experience" (Geiger 1958:61). For Dewey an important factor was sensitive awareness and knowledge as a kind of experience.

When one considers Dewey's writings in relation to teaching, one realises that students need to be helped to become aware. The significance of learning situations and opportunities and contextual learning, inter alia, then take on a new meaning. Dewey's remarks that experiences need to be integrated also have significance in teaching, for this may not necessarily come naturally or easily for every student.

7.1.2 SCHON

Schon's concept of reflection-in-action becomes meaningful in helping students to integrate their experiences and gain knowledge. "Reflection-in-action in the context of reflective practice is soundly based on the concepts of model I and model II behaviour, where model I is seen as the traditional client / professional relationship and model II as the foundation of reflective practice" (Powell 1989:825). Schon states that in order to develop model II

behaviours, a special learning process is required. It must "...involve the learner and the teacher in reflecting on the discrepant theories they may employ when faced with conflicting situations" (Andrew 1998:74). Schon also speaks of reflective practice. For Schon this includes reflection-in-action and reflection-on-action. The former requires that one thinks about what one is doing while doing it and the latter, that one analyses one's actions and understands one's actions in terms of the outcomes. The former allows one to change one's course of action while doing it. The latter is a post-action cognitive behaviour (Greenwood 1998: 1049). Greenwood (1998: 1051) goes on to quote Johns who says that "... learning through reflection is an emancipatory activity."

Polanyi's statement "we know more than we can tell" (Powell 1989:825) has meaning for a curriculum which adopts an experiential approach.

7.1.3 VAUGHAN AND PEARSON

Vaughan (1992) speaks of nursing knowledge and the knowledge of practice. In writing about knowing in nursing she draws on Carper's taxonomy of nursing knowledge, viz. empirics, ethics, aesthetics and personal knowledge. While each of these have made a significant contribution to the scientific body of nursing knowledge, knowledge in each of these domains has been gained through different means. However, these domains do not always reflect the form of knowledge which is used by expert practitioners. She goes on to say (1992:16) "... but the knowledge of practice is not valued nor is it readily available or accessible through others." She quotes Schon and Benner who have both written of the lack of recognition given to the learning of the practice of nursing. Pearson (1992:222) is critical of the "theorizing" which he says has "become more sophisticated" and which has "become less useful for guiding our understanding of nursing practice." He calls for theorizing which incorporates action, for he says (1992:223) "... as a practice discipline, nursing is grounded in action." These views are consistent with those of Heron (Lowe and Kerr 1998: 1031) who proposes three types of learning that are necessary. These are:

- a factual knowledge base - this information is mainly acquired in the classroom,
- practice knowledge, and
- periential learning.

In summary, an experiential curriculum approach has the characteristics of being subjective, personal and transactional. These properties personalize the programme and foster the individual's growth and maturity. This development of the individual is grounded in an "ever-becoming." An experiential approach to learning recognizes that not all experiences are equally valuable and that while experience is a natural phenomenon, one is not always aware of one's experiences. Thus if one is to learn in such an approach, awareness and the ability to contextualise the experience must be developed. It is in becoming aware that new meaning is given to an experience. Becoming aware is dependant on reflection of the experience. These activities involve the learner and thus an experiential approach is learner-centred. Becoming aware and reflection are essential qualities in meaningful nursing practice and can be used in both the knowledge and practice base of nursing.

Based on an experiential approach, a thematic model is proposed for the teaching and learning of women's health. Suggested themes are those which were identified in chapter five (vide 5.5.3 p 259) and which are supported by the findings of this study, viz.
nursing \ midwifery
communication
teach \ learn
growth and development
health determinants and issues
profession
health care system (vide 7.8.2.2 p 290 for definition of themes.)

These themes were developed by identifying the concepts and needs associated with a teenage pregnancy. These themes arise from the concepts and principles encountered in the

knowledge base, the practice base and from experiential learning.

7.2 THE CURRICULUM DEVELOPMENT

7.2.1 UNDERLYING CONSIDERATIONS FOR CURRICULUM DEVELOPMENT

In considering the application of an experiential model to the curriculum development, consideration had to be taken of issues dictated by controlling bodies at a national level. These are the Department of National Education, the Department of National Health and the South African Nursing Council. The influence of these controlling bodies can be described as follows:

7.2.1.1 The Department of National Education controls university degrees. In relation to vocational degrees it prescribes the minimum number of courses which must be offered in the degree. In addition, it also prescribes the ratio of non-vocational or natural sciences to the vocational or clinical sciences. The South African Post-Secondary Education Report, No.115 (1982:11) states that "although it is important for universities to keep in close touch with the needs of the community, and to serve the community, it is also important that universities should not concentrate so heavily on service to the community in preparing students for a profession that the scientific or academic or theoretical grounding of students is neglected. It remains the primary function of a university to turn out products that have, first and foremost, a fundamental scientific grounding." It goes on to state that it is the function of the university to prepare students to practise a profession for which society considers a university education to be necessary. The report states that curricula should engender life-long learning and self-directed learning in the student. A professional degree has to be four years in duration and "..., at least half of the curriculum for a four-year degree should consist of subject courses derived from the basic natural sciences, the humanities, and the social sciences" (SAPSE - 115 1982:59). In addition, each year of study must have a minimum of four year courses.

7.2.1.2 The Department of National Health and the health care structure has an influence on the curriculum design in that education must prepare practitioners suitable for the service

and capable of meeting the needs of the people of the country. In 1995 de Witt wrote that numerous changes had taken place in the health care service in an attempt to address the imbalances between the curative and preventive services. She goes on to say that it was envisaged that a comprehensive health care approach together with the influence of the Alma Ata conference of 1978 would result in the development of a new health service management for the country. The paradigm shift was from a curative model to a comprehensive care model with community involvement. Legislation to transform the health care service was passed in 1977 in the Health Act, (Act 63 of 1977). This shift impacted on nursing education and influenced the development of the comprehensive nursing education programme. In addition, nurses were identified as the key persons in rendering such a service.

7.2.1.3 The South African Nursing Council regulates the professions of nursing and midwifery (South African Nursing Council regulations R425 of 1985). It does so by defining the midwife's scope of practice and by regulating the conditions under which she may carry out her profession. Not only does it control her practise, but it also controls nursing education. In response to the Department of Health's paradigm shift, van Huyssteen, in her research, (1981:331) assessed the preparedness of the nursing profession to meet the needs of such a philosophy and health structure. She found that in 1979 only 4,7% and 8,7% of all registered nurses held a registration in community health and psychiatric nursing respectively. In addition, van Huyssteen found that the facilities available for the training of community health nurses were insufficient (van Huyssteen 1981:331). Thus, it is clear that the paradigm shift had major implications for nursing education. In order to meet the challenge van Huyssteen proposed that the preparation of nurses should include preventive, promotive, curative and rehabilitative care for communities, families, groups and individuals. In order to meet the health care needs of the community she proposed a comprehensive practitioner - one who is educated in general, psychiatric, and community nursing and midwifery and who is prepared to meet needs within and outside health institutions (van Huyssteen 1981). This was not the first call for an integrated approach to nurse education in the country. In 1945 the South African Nursing Council called for an end to the fragmented approach and in 1977

Williamson recommended an integrated course which led to multiple registration (Gwele 1995:5). This recommendation was adopted by the South African Nursing Council and was promulgated in Government notice R2118 of 30 September 1983. This regulation was later amended and replaced by Government notice R425 of 22 February 1985.

The philosophy of the South African Nursing Council is described in a document entitled "The Philosophy and Policy of the South African Nursing Council with regard to Professional Nursing Education." (See Annexure P).

The philosophy includes definitions of nursing and nursing science. It identifies the registered nurse as the person responsible for nursing education and states the purpose of nursing education. The policy incorporates the concepts of a comprehensive health service, a scientific approach to nursing, awareness of socio-cultural factors, minimum standards, the development of special knowledge and skills, the purpose of learning and standards for clinical practica.

The influence of these controlling bodies is diagrammatically illustrated in figure 7.1.

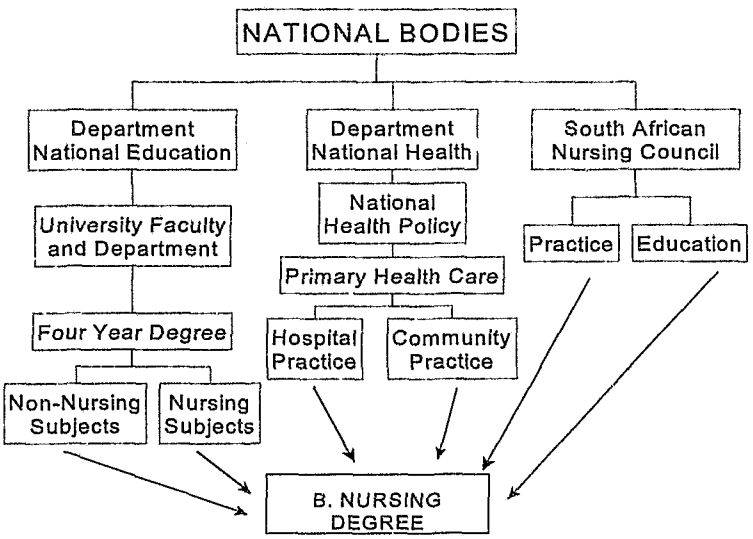


Fig 7.1 Diagrammatic representation of bodies that influence curriculum design

7.2.1.4 Factors which influence the curriculum at a local level. Consideration must also be taken of the issues which operate at a local level. These may be identified as the university policies, the faculty policies and the department's policies. University and faculty policies influence the curriculum in terms of length of courses, course evaluation and examinations. The university and the faculty are based in tradition and are reluctant to change. Integration of subject matter is made more difficult by the fact that the basic sciences are taught by the relevant departments and therefore in isolation from the nursing courses. The university is faced with budget cuts as national subsidies have been decreased and the financial constraints have resulted in the rationalisation of courses offered. This has meant that courses have become more core focused, with a move away from the discipline specific needs. These courses are usually taught in the traditional manner and therefore students have to contend with a dual system of education. These classes are usually large in number and make use of the lecture method for teaching and learning. Departmental policies may influence the curriculum through its philosophy and its approach to the curriculum design, where emphasis is on small group and experiential learning and is self-directed. It is mainly at the departmental level that the ability to influence the curriculum is possible. Despite the many considerations which need to be heeded, the ability to offer a dynamic curriculum is not impossible, because it is at this level that the curriculum is operationalised.

7.3 IMPLICATIONS FOR A CURRICULUM IN WOMEN'S HEALTH

Aspects of the philosophy and regulations which are pertinent to this study are:

- duration of the course is four academic years;
- midwifery is a subject that shall be included. It should be taught over at least two academic years;
- examinations shall be conducted in the subject and the theory and practica shall be examined and passed separately;
- the programme objectives. Whilst they all have a bearing on midwifery, significant aspects are the reference to individual, family and community problems, the provision

of care at any point along the health\illness continuum and in all stages of the life cycle; the ethical and moral codes of the profession; collaboration with the multidisciplinary team; ability to evaluate personal practice and takes responsibility for continuing professional and personal development and is able to promote community involvement (Regulations relating to the approval of and the minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwife leading to registration. R425 of 1985). In addition, the amended regulation R425 of 1994 provides guidelines for the subject content which should be taught in midwifery. In the guidelines for midwifery practice it, inter alia, states that 1000 hours should be obtained in the preventive, promotive, curative and rehabilitative aspects of midwifery practice. This amendment has placed greater emphasis on the preventive, promotive, curative and rehabilitative aspects of health care. Such an approach is an effort to better align the nursing curriculum with the needs of a primary health care orientated health care system. It seeks to prepare practitioners who are better prepared to function in a variety of health care settings;

- the university's policy regarding methods of summative assessment is traditional and dictates the number of examination papers for first and second courses;
- the university policy of the length, in terms of hours, of final examination papers for qualifying courses, and
- the emphasis which is still placed on marks and grades and the limits set at which the percentage of formative assessment may count towards the final mark. (See Annexure Q).

7.4 PHILOSOPHY OF THE DEPARTMENT OF NURSING

The philosophy endorses the values and objectives of the university's Mission Statement (see Annexure R). In addition, the following beliefs are basic to the approach of education in nursing:

7.4.1 THE ENVIRONMENT

This considers communities, families and individuals and their state of health and well being. Each individual in the family and the community is recognised as a unique and self-directed being, capable of expressing herself in psychological, physical, emotional, spiritual, social and cultural terms. Each has the ability to change and grow within these dimensions. Each has needs which are evaluated and responded to according to norms, values and beliefs. In addition, each individual has attributes which can be enhanced in order to promote health. The status of the individual impacts on the family and the community. Health is a state in which an individual, family or community is able to function optimally, either independently or with assistance. It is a state which can be improved through health promotion and prevention of disease, intervention and rehabilitation. While it is recognised that every individual has a right to health, it is also acknowledged that each individual has a responsibility to maintain her health through self-care.

7.4.2 THE REGISTERED NURSE AND MIDWIFE

Nursing and midwifery are practice based professions that have developed through art and science. Practice involves the use of critical thinking and sound judgement based on theoretical knowledge. It includes the provision of professional, skilled and empathic care. Caring is culture sensitive. It is evidenced in skills, attitudes and communication, where competence, respect and the enhancement of human dignity manifest. It encompasses a moral dimension in which the essence of nursing and midwifery and the physical and spiritual dimensions of the cared for are recognised. Caring is other regarding; it considers the needs of others before one's own. The behaviour of the one-caring is unique to that caring moment and in turn its interpretation is personal to the cared-for.

The caring practitioner is research minded in that her use of theoretical knowledge is research based and the development of knowledge is research dependent.

7.4.3 THE CURRICULUM

Participation in the curriculum places the student in the tertiary level of education. Learning is student-centred, prepares the student for practice and leadership roles and thus it embraces the values of lifelong learning, self-directed learning and critical thinking. The role of the teacher is one of a facilitator of learning in which he or she is a co-learner. The curriculum is activated through the use of nursing and midwifery problems and situations and the facilitator. Practical learning opportunities are obtained in diverse settings which include differing levels of care and cultures. The curriculum takes cognisance of the health care system and the needs of the community.

7.4.4 THE OUTCOME

The graduand is a professional nurse and midwife who recognises her caring responsibilities to the community, family and individual. These responsibilities include the promotive, preventive, curative and rehabilitative dimensions of health and illness. They are performed within cultural, moral, ethical and legal frameworks in which she acknowledges her accountability for her actions and advocacy for her clients and patients.

7.5 CURRICULUM DEVELOPMENT FOR WOMEN'S HEALTH

Taking the above considerations into account and applying them to women's health, cognisance needs to be taken of four essential aspects:

- the curriculum for women's health must extend over two academic years;
- the core of the course needs to be reproductive health and childbirth, but there is no limitation on integration and extension of the course;
- evaluation must include examinations - in both the theoretical and the practical aspects;
- attention needs to be given to the preparation of women's health practitioners who are capable of community as well as hospital based practice.

In addition, the findings of the needs assessment must be considered. These are:

- the statistics which reflect the incidences of normal deliveries as compared with

- the statistics which reflect the incidences of normal deliveries as compared with complications. This guides what is essential in the curriculum content;
- the statistics which reflect the health problems and needs of non-pregnant women;
- the need for health promotion;
- the concept of caring needs to enhanced. Professional qualities and ethical and moral values need to be developed;
- the development of an understanding of the health care structure in its role of meeting health needs. Where services are found to be wanting in their role and function or where there is a need for a service, practitioners must be able to be proactive and empowered to take action;
- the development of research understanding. This is necessary to produce practitioners whose care is based on scientific knowledge and understanding. It is also necessary in the development of leadership;
- an understanding of the processes of teaching and learning are necessary. This does not only apply to the individual herself, but also in the development of future students and in the promotion of health;
- an understanding of the society and its cultures is essential in providing holistic care. The influence of environment, in its broadest terms, on an individual needs consideration.

7.6 CONCEPTS TO BE CONSIDERED IN CURRICULUM DEVELOPMENT

Given the experiential approach to the curriculum development (vide 7.1 p 271) and the above considerations, the concepts on which the curriculum is developed are:

integration of subject matter;

lateral thinking;

problem solving;

critical thinking,

self-directed learning, and

experiential learning.

7.6.1 DEFINITION AND DESCRIPTION OF THE CONCEPTS

- **integration of subject matter**. This refers to the integration of nursing and midwifery knowledge across the four major nursing disciplines.(See Annexure S for the integration of the nursing disciplines.) In addition, content from the non-nursing courses are integrated into the learning packages in order to reinforce application of knowledge.
- **lateral thinking** evolves out of integration of subject matter. It encourages the use of knowledge from other disciplines in order to more fully understand and explain the content being learned. It gives significance to understanding and a scientific basis for actions. It will be facilitated through dialogue in small group learning.
- **problem solving** refers to the ability to be able to identify problems or potential problems; to be able to suggest causes for the problems or suggestions to improve the situation before a problem arises and to be able to suggest means to solve the problem or improve the situation. The adoption of a plan to solve the problem or to improve the situation facilitates the learning of decision making. Learning of this skill will be facilitated through dialogue, discussion and debate of actual problems / situations.
- **critical thinking** refers to the ability to identify and challenge assumptions; to challenge the importance of context; to think creatively and explore alternatives. (Vide 2.2.2 p 30) In 1980 Watson and Glaser (Sandor, Clark, Campbell, Rains and Cascio 1998:24) described critical thinking as a collection of attitudes, knowledge and skills. However, Haffer and Raingruber (1998:61) state that "... there is disagreement regarding whether clinical reasoning and critical thinking are primarily cognitive activities or skill-based practices incorporating social, affective, and embodied ways of knowing." In implementing critical thinking in this curriculum critical thinking will include attitudes, knowledge and skills. Critical thinking will be fostered through the use of concept analysis, dialogue, self-assessment, experiential learning and reflective learning. (For the use of dialogue in critical thinking vide 3.2, p 74, and for the use of

self-assessment in critical thinking vide 2.2.1 p 29). Concept analysis as a means of developing critical thinking had been advocated by Kemp (1985). She writes (1985:384) that concept analysis encourages organized investigation of abstract ideas, improves clarity and preciseness in communication, promotes understanding of frameworks and provides a process for operationalizing variables for research. Experiential learning and reflection are very closely aligned. Dewey states that one needs to be aware of one's experiences. Burnard (1992:155-6) states that experiential learning "...,is an active rather than a passive form of learning. ... that ... (it) is personal learning ... and that ... the person also reflects on what he or she is doing in order to learn." Active learning suggests that the student is involved in the process and is doing. This suggests the learning of skills. Experiential learning has also been advocated for the learning of inter-personal skills. Burnard (1992:156) compares personal learning with public knowledge. He suggests that in experiential learning we learn something that is personal to us. This he compares with the lecture method where knowledge is obtained from the public domain. In order to personalise knowledge, it is necessary to reflect on the experience. Boud, Keogh and Walker (Davies 1995:167) have stated that "..., to be engaged in reflection, learners must actively draw on their past experience, describe the experience, work through their attitudes and emotions relative to the experience, and then order and make sense of new ideas and information." Davies (1995:167) states that reflection is a complex process. Cognition and feelings are linked and the two have to be interpreted in relation to one another. Methods of encouraging reflective learning which have been described in the nursing literature are the use of interactive journals (Tryssenaar 1994), clinical debriefing sessions and journalling (Davies 1995), diary writing (Richardson and Maltby 1995), peer journals (Cameron and Mitchell 1993) and story telling (Heinrich 1992). Haffer and Raingruber (1998:62) state that narratives "... provide experiential learning crucial to developing expertise in a skill-based practice such as nursing." They (1998:62) quote Benner who has said that in order to learn from another's narrative, the learner must "actively rehearse or imagine the situation."

Furthermore, Benner, Tanner and Chesla (Haffer and Raingruber 1998:63) have stated that "narratives incorporate all the domains of knowing by 'integrating feelings, thoughts, perceptual recognition, and memory.'" Thus it would appear that story-telling or narratives provide an opportunity for experiential and reflective learning. The learner is given opportunity to hear feelings from a personal point of view, as well as to build on similar and dissimilar narratives and so build a repertoire of understanding. However, in order to develop critical thinking students need to be empowered to think critically. Encouraging students to ask questions requires trust and a safe environment. This can be developed through dialogue and the use of scenarios. In addition, dialogue and communication offer opportunity for culturally diverse groups of students to learn about culture, values and beliefs. Kirkpatrick, Brown and Atkins (1998:15) state that "in today's rapidly changing world, it is reasonable to expect that all baccalaureate nursing students be culturally competent." Andrew (1998:77) warns that unspoken reflection and negative criticism may be detrimental to learning. For Diekelmann (1990b) dialogue, together with caring and practice , is one of the central issues in the curriculum revolution. For her, dialogue is engaged listening and a means to understanding. It encourages and develops in one the quality of being open to all possibilities. Through the use of words one is able to reflect and to probe and therefore to improve understanding. Dialogue encourages the sharing of experiences. It facilitates the "becoming aware" of the experience and the contextualising of that experience. Reflection is more than a cognitive activity. It can be said that it is dialogue that enhances this activity through the sharing and debate of the meaning of the experience and the actions with which it was associated.

- **self-directed learning** is learning through the identification of own learning needs. It is facilitated through self and peer assessment. It is dependent on the ability to be able to access information and to be able to maximize the use of libraries and information technology. It is guided by the facilitator. (Vide 2.2.1 p 29 for further discussion.)

7.7 PROGRAMME GOALS

The overall curriculum for the degree assumes an integrated approach and therefore the programme goals are described.

Within the context of the mission of the university and the philosophy of the department, the graduand will be able to:

- utilise principles of health, human development and nursing to develop, implement and evaluate strategies for the prevention of illness and injury and the promotion and enhancement of health;
- demonstrate an understanding of the structure and function of the human body, pathophysiology, pharmacology and social processes which underpin nursing practice and use this knowledge to optimise assessment, clinical decision making, treatment, care and ongoing evaluation of nursing practice;
- communicate effectively with individuals, families, significant others and members of the health care team in order to promote meaningful interpersonal relationships and to facilitate health care delivery and multidisciplinary comprehensive team work;
- demonstrate sound clinical judgement in the provision of multidisciplinary comprehensive nursing care for individuals and groups across the age continuum and in collaboration with them;
- promote community involvement in the development of health programmes motivating individuals and communities to take responsibility for their own health;
- function within legal and ethical parameters and acceptable standards of practice;
- demonstrate professional caring within the South African multicultural society, acknowledging human rights and responsibilities;
- demonstrate an understanding of the theoretical underpinning of nursing and midwifery knowledge and their development as disciplines;
- reflect on and critically evaluate their own practice;
- demonstrate understanding of the factors which affect health care outcomes;
- critically evaluate nursing research and demonstrate an understanding of its

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